Public Board Meeting

Thu 25 September 2025, 09:30 - 14:30

Woodland House, Coed Y Bwl

Agenda

09:30 - 09:30
0 min

1. Welcome & Introductions

Ceri Phillips

09:30 - 09:30
0 min

2. Apologies for Absence

Ceri Phillips

09:30 - 09:30
0 min

3. Declarations of Interest

Ceri Phillips

09:30 - 09:35
5 min

4. Minutes of the Board meeting held 31.07.2025

Ceri Phillips

- 4. Minutes of the Public Board Meeting 31.07.2025.pdf (15 pages)

09:35 - 09:40
5 min

5. Action Log – following meeting held on: 31.07.2025

Ceri Phillips

- 5. Action Log - Public Board (7).pdf (2 pages)

09:40 - 13:55
255 min

6. Items for Review and Assurance

6.1. Patient Story - I've gone from frail to robust - David's Story (15 MINUTES)

Jason Roberts

6.2. Chair’s Report & Chair’s Action taken since last meeting (10 MINUTES)

Ceri Phillips

- 6.2 Chairs Board report September.pdf (7 pages)

6.3. Chief Executive Officer Report (15 MINUTES)

Suzanne Rankin

- 6.3a Appendix 1 - CEO Report Staff Winter Flu image Sept 25.pdf (1 pages)
- 6.3 CEO Board Report September Final (1).pdf (7 pages)

6.4. Finance & Performance Committee Chairs Report (10 MINUTES)

Catherine Phillips / John Union

- 6.4 F&P Chairs Report 17.09.2025.pdf (3 pages)

6.5. Board Assurance Framework (10 MINUTES)

Matt Phillips

- 6.5 BAF_Board Cover Report.pdf (3 pages)
- 6.5a BAF (2).pdf (38 pages)

6.6. Chairs' reports from Committees of the Board (15 MINUTES)

Matt Phillips

1. *Quality 05.08.2025*
2. *Digital & Infrastructure 12.08.2025*
3. *Mental Health Legislation 26.08.2025*
4. *Audit & Assurance 02.09.2025*

- 6.6.1 - Quality Committee Chairs Report 05.08.2025.pdf (3 pages)
- 6.6.2 Digital & Infrastructure Chairs Report 12.08.2025.pdf (4 pages)
- 6.6.3 - Mental Health Legislation Committee Chairs Report 26.08.2025.pdf (4 pages)
- 6.6.4 Audit and Assurance Chairs Report 02.09.2025.pdf (4 pages)

6.7. Strategic Planning, Commissioning and Partnership Update (10 MINUTES)

Catherine Phillips

- 6.7 Strategic Planning Commissioning and Partnerships Update (1) (1).pdf (9 pages)

6.8. BREAK – 10 MINUTES

6.9. Ministerial Advisory Group Report Update (15 MINUTES)

Adam Wright

- 6.9 Ministerial Advisory Group Report Update - Board Cover Paper (1).pdf (4 pages)
- 6.9 Ministerial Advisory Group Update - September Board.pdf (5 pages)

6.10. Theatre Service Review Update (10 MINUTES)

Adam Wright

- 6.10 Theatres Together - Board Update September 2025 FINAL.pdf (3 pages)
- 6.10a Theatres together Improvement Plan V1.2 FINAL.pdf (27 pages)

6.11. Integrated Performance Report (75 MINUTES)

- *Finance*
- *Public Health*
- *Operational Performance*
- *Quality, Safety & Experience*
- *People & Culture*
- *Digital*

- 6.11 IPR cover report v2.pdf (26 pages)
- 6.11a Integrated Performance Report v2.pdf (45 pages)

6.12. LUNCH - 30 MINUTES

6.13. Strategic Portfolios (25 MINUTES)

Catherine Phillips

- 6.13 Strategic Portfolio Executive Steering Group (1).pdf (6 pages)

13:55 - 14:25
30 min

7. Items for Approval / Ratification

7.1. Business Cases (10 MINUTES)

Catherine Phillips

7.1.1 - Llantrisant Health Park Outline Business Case 1 *(noting – no approval required)*

The business case can be located in the supporting documents folder.

- 7.1.1 LHP OBC Board 25.09.2025.pdf (4 pages)

7.2. Terms of Reference & Remit of the Regional Joint Committee (10 MINUTES)

Matt Phillips

- 7.2 RJC joint Board paper Final.pdf (4 pages)
- 7.2a SERJC_TORs_Final.pdf (14 pages)

7.3. NWJCC Scheme of Delegation and Reservation of Powers (10 MINUTES)

Matt Phillips

- 7.3 Reservation of Powers and Scheme of Delegation.pdf (8 pages)
- 7.3a Appendix 1 - Reservation of Powers.pdf (3 pages)
- 7.3b Appendix 2 - SoD V3.3 (1) (1).pdf (2 pages)

14:25 - 14:25
0 min

8. Items for Noting and Information

8.1. Corporate Risk Register

Matt Phillips

- 8.1 CRR Board Report - Sept 2025.pdf (3 pages)
- 8.1a Corporate Risk Register Sept 2025.pdf (7 pages)
- 8.1b CEF Coporate Risk Register Sept 2025 (1).pdf (6 pages)

8.2. Reports from Advisory Groups and Joint Committees:

1. NWSSP Assurance Report 17.07.2025

The reports can be located in the Supporting Documents Folder.

8.3. Committee and Advisory Group Minutes:

1. Joint Commissioning Committee 15.07.25
2. Digital & Infrastructure 27.05.2025
3. Quality 05.08.2025

All of these minutes can be located in the Supporting Documents Folder

14:25 - 14:25
0 min

9. Agenda for Private Board Meeting

i. *Approval of Private Board minutes*

ii. *Southeast Wales Regional Orthopaedic Plan*

iii. *Legal Update (Verbal)*

iv. *People & Culture Update*

v. *National Pay Settlement* (Verbal)

vi. *Cardiff Health Partners (CHP) Prospectus*

vii. *Approval of Private Committee minutes*

14:25 - 14:25
0 min

10. Any Other Business

10.1. Review of the meeting

Ceri Phillips

10.2. Date and time of next meeting:

Thursday 27 November 2025 – Woodland House – *Coed Y Bwl*

14:25 - 14:25
0 min

11. Declaration

To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]

Minutes of the Public Board Meeting
Woodland House, Coed Y Bwl
31 July 2025

To view a recording of the meeting, please click here. You can also click the title of each section in these minutes which will take you to that item on the recording.

Chair:		
Charles Janczewski	CJ	University Health Board Chair
Present:		
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
Joanne Brandon	JB	Director of Communications, Arts, Health Charity and Engagement
Lauranne Cullen	LC	Regional Director - Llais
David Edwards	DE	Independent Member – ICT
David Fluck	DF	Executive Medical Director
Rachel Gidman	RG	Executive Director of People & Culture
Mike Jones	MJ	Independent Member – Trade Union
Susan Lloyd Selby	SL	Independent Member – Local Authority
Clive Morgan	CM	Deputy Director of AHPs, Health Scientists & Community Services
Sara Moseley	SM	Independent Member – Third Sector
Catherine Phillips	CP	Executive Director of Finance
Ceri Phillips	CP	University Health Board Vice Chair
Matt Phillips	MP	Director of Corporate Governance
Suzanne Rankin	SR	Chief Executive Officer
Steve Riley	SR	Independent Member – University
Jason Roberts	JR	Executive Nurse Director
David Thomas	DT	Director of Digital & Health Information
Rhian Thomas	RT	Independent Member – Capital & Estates
Lani Tucker	LT	Chair of the Stakeholder Reference Group
John Union	JU	Independent Member – Finance
Observers:		
Daniel Burke	DB	Management Graduate Trainee (left at midday)
Bevan Howells	BH	Management Graduate Trainee (left at midday)
Katie Powell	KP	Management Graduate Trainee (left at midday)
Nia Tate	NT	Management Graduate Trainee (left at midday)
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Emma Cooke	EC	Executive Director of AHPs, Health Scientists & Community Services
Rachna Upadhya	RU	Independent Member

Ref	Agenda Item	
UHB 25/07/1	**Welcome & Introductions (click to view)** The UHB Chair welcomed everybody to the meeting in English and Welsh.	
UHB 25/07/2	**Apologies for Absence (click to view)** Apologies for absence were noted.	
UHB 25/07/3	**Declarations of Interest (click to view)**	

	The Independent Member – Third Sector (IMTS) declared that she had been appointed as the Chair of Velindre University NHS Trust.	
UHB 25/07/4	**Minutes of the Board Meeting held 27.05.2025 and the Special Board Meeting held 25.06.2025 (click to view)** The minutes or the Board meeting held 27.05.2025 and the Special Board meeting held 25.06.2025 were received. • The CEO queried a paragraph within the minutes that did not align to the discussion held. • The Executive Director of Public Health highlighted a formatting error whereby the page number had ended up within the body of the text. It was agreed that the Senior Corporate Governance Officer would amend the minutes to reflect the accuracy raised. **The Board resolved that:** a) The minutes of the Board Meeting held 27.05.2025 and 25.06.2025 were approved as a true and accurate record of the meeting pending the two amendments.	
UHB 25/07/5	**Actions – Following Meeting held 27.05.2025 (click to view)** All actions were received and reviewed. **The Board resolved that:** a) The Actions – Following Meeting held 27.05.2025 were noted.	
UHB 25/07/6.1	**Patient Story – It's so important to know basic life support – Keith and Lynn's Story (click to view)** The Patient Story was received. The Executive Nurse Director (END) introduced the video and explained that it provided the Board with Keith's story, a powerful patient story that outlined the importance of the Chain of Survival - a series of actions that, when performed promptly and effectively, greatly increased the chances of survival and recovery. The video explained that Keith had experienced a collapse in an off ward area, where cardiac arrest occurred infrequently and was managed effectively by the prompt action of staff following training by the Resuscitation Service. The Independent Member – University (IMU) highlighted to the Board that Wales had one of the lowest survival rates in Europe and the lowest in the UK if someone suffered an out-of-hospital cardiac arrest. He added that the low survival rate was partly attributed to a lack of widespread CPR training, particularly among young people and noted that a Cardiff University project was attempting to address that by training students in life-saving skills. The CEO commended the staff who had reacted so well in the situation especially as it would have been an unfamiliar scenario to them. She added that she had reflected on the discussions held around Cardiff and Vale UHB and the University Hospital of Wales (UHW) being a Cardiac Arrest Centre and the effective commissioning (or not) of that and noted that the Health Board were already running as a Cardiac Arrest Centre but work was needed on what that meant exactly because the Health Board were not commissioned for that service in a formal and effective way.	

	It was noted that a further conversation with the Joint Commissioning Committee (JCC) would be required about how it could be taken forward. **The Board resolved that:** a) The Patient Story was noted.	
UHB 25/07/6.2	**Chairs Reports & Chairs Action taken since last meeting (click to view)** The Chairs Report was received. The UHB Chair advised the Board that he would take the report as read and highlighted key points which included: • Kirsty Williams would become Chair of Cardiff & Vale University Health Board on 1 October 2025. It was noted that she was currently Vice Chair at Powys Teaching Health Board and had significant experience in healthcare and public service. • Sara Moseley, Independent Member – Third Sector (IMTS) at Cardiff and Vale University Health Board, had been named Chair of Velindre University NHS Trust, starting 1 September 2025. The Board recognised and thanked Sara for her 8 years of service. • Clive Curtis was welcomed to his first Board meeting as the new Independent Member for Community (IMC). It was noted that he would support the Quality, Committee, Mental Health Committee, and People & Culture Committee and that he brought experience in governance, operational management, health & social care, and the third sector, which would contribute to the Board's work. • Condolences for the sad loss of former Executive Nurse Director Ruth Walker. The UHB Chair highlighted her significant contributions to the organisation and the NHS overall. He noted that Ruth was a monumental force for good within the organisation and widely respected across Wales and nationally. • Armed Forces Week was highlighted as the spotlight story for the month, which focused on the Board's work with the armed forces. The Independent Member, ICT (IMICT) was specifically acknowledged as the Board's Armed Services champion who attended the launch event and gave a speech alongside the Minister for Mental Health, Sarah Murphy. Thanks were extended to the IMICT, the Director of Corporate Governance (DCG), and Maisie Proven, the Health Boards Armed Forces Lead for their ongoing work and strong relationships with the Armed Forces. It was noted that the report would be updated to reflect the contributions of the IMICT. **The Board resolved that:** a) The report was noted. b) The Chair's Actions undertaken were approved. c) The application of the Health Board Seal and completion of the Agreements detailed within the report were approved.	
UHB 25/07/6.3	**Chief Executive Officer (CEO) Report (click to view)** The CEO Report was received.	

The CEO advised the Board that she would take the report as read and noted that the report was themed around celebration and success highlighting that Health Board colleagues delivered amazing care.

She added that the report balanced some of the more challenging news that the Health Board had received and expressed her disappointment on the escalation status to include all elements of the Organisation.

The Board was advised that the Health Board's escalation status was broadened to include all organisational elements due to missed targets in financial delivery, care, and diagnostics, despite some improvements.

The CEO highlighted other key areas in the report which included:

- The NHS was 77 years old. Despite many challenges mentioned in media and institution, it remained a very important part of the UK's culture, people's approach to life and what was important to everybody.
  The CEO added that the NHS was founded in Wales by Aneurin Bevan and that it was important to reflect that.

- A number of colleagues had been identified in Kings Honours and included the Health Board's own Professor Meriel Jenney for services to cancer treatment and research in children and young people.

- Volunteers & Staff Engagement: Volunteers were praised for their essential contributions and described inspirational events celebrating their impact. Leadership listening walkarounds were introduced as a systematic approach to improve culture and governance.

- Digital Healthcare Progress: Electronic prescribing and medicines administration (EPMA) rollout had begun, marking a key milestone for digital transformation and safety. Thanks were provided to the END, the Chief Clinical Information Officer and their teams.

- Partnership Working: The report stressed the importance of investing time in partnerships and strengthening relationships, with examples from the Partnership Asset Management Board and the estate rationalisation work led by the Executive Director of Finance (EDF)

- Solar panelling being installed at the University Hospital of Wales (UHW). The CEO emphasised its role in cost reduction and meeting government decarbonisation targets. Additional mitigations and communications had been implemented around car parking.

The CEO advised the Board that a Climate Emergency Ask Suzanne session was taking place on 1 August 2025.

- Financial Position: it was noted that the Health Board was committed to delivering a £56.2m forecast, with ongoing discussions about further savings and overhead reductions. Assurance was provided to Welsh Government (WG), and more details were to be discussed later in the meeting.

The CEO concluded that the Health Board were awaiting the de-escalation framework criteria from WG colleagues.

The UHB thanked the CEO for covering the escalation process thoroughly and acknowledged the adverse news of the Health Board's escalation status being expanded across all domains, noting it was unfortunate to be escalated twice in the same calendar year and expressing concern about the potential impact on morale.

	He added that the escalation should be viewed positively, as it brought extra support and scrutiny intended to help restore areas of underperformance, not to hinder the organisation. He also noted that leaders and teams should be encouraged to maintain a positive outlook, maximise the support provided, and strive for de-escalation. **The Board resolved that:** a) The Strategic Overview and Key Executive Activity to provide assurance described in the report were noted.	
UHB 25/07/6.4	**Finance & Performance Committee Chairs Report (click to view)** The Finance & Performance (F&P) Committee Chairs Report was received. The UHB Chair introduced the report following the recent Finance & Performance Committee meeting, highlighting the focus on the organisation's financial situation and performance issues. The EDF provided the finance update, noting that it was the first month reporting against the revised £56m target, with a current shortfall of £1.158m, mainly due to savings gaps. She added that £28m in savings schemes were classified as green/amber, with £6-7 million in red schemes needing conversion to green for full delivery. It was noted that operational pressures included mental health out-of-area placements, contract overperformance (notably in critical care), and national insurance funding shortfalls with the Health Board operating with a £0.314m operational deficit. The Independent Member – Local Authority (IMLA) advised the Board that the Committee had also discussed the need for clear timescales to address savings shortfalls and the importance of accurate data triangulation. The CEO recognised the challenging position the Health Board were in but wanted to provide assurance around grip and control. She noted that the operational shortfall of £0.300m was a vast improvement on the previous year and that the control on operational expenditure had been significantly strengthened but concerns remained about demand pressures, especially heading into winter. She added that she was relatively pleased with the operational position, however noted that it could not grow and ideally it would be brought back to £0. **The Board resolved that:** a) The contents of the report were noted.	
UHB 25/07/6.5	**Board Assurance Framework (click to view)** The Board Assurance Framework (BAF) was received. The Director of Corporate Governance (DCG) advised the Board that the strategic risks were aligned to different Committees, with the Quality Committee and the Digital and Infrastructure Committee handling more significant portions of the risks. He added that any changes were highlighted within the BAF itself and noted that the focus remained on connecting the strategy through the strategic portfolio to ensure strategic risks were properly addressed and aligned with Committee oversight. The Board were advised that off the back of the Finance & Performance Committee the prior week, there was now a programme of how long-term financial planning would be	

	brought back to the Committee to ensure a horizon look at the finances as well as the day to day pressures identified in the F&P Chairs Report. The DCG noted that decarbonisation/climate formed a key part of the sustainability risk and would feature at the F&P Committee in future (every other month) and then Research & Development would be provided an outlet through the Committee also. **The Board resolved that:** a) The risk themes regarding the delivery of Strategic Objectives detailed on the BAF were reviewed and noted.	
UHB 25/07/6.6	**Chairs Reports from Committees of the Board (click to view)** The UHB Chair invited Chairs of the Committees to provide any updates from the previous meetings held. **Digital & Infrastructure (click to view)** • The capital plan was highlighted, noting an increase of £2.12 million in discretionary capital allocation, now at £17 million. • Maintenance backlog stood at £175 million, underscoring significant challenges for the organisation. **Charitable Funds (click to view)** • Annual accounts for March 2025 were reviewed, subject to audit. • Rathbone's investment update was received. • A decision was made to proceed with hiring for the fundraising team, with further details to be provided at a future meeting by the EDF. **Quality (click to view)** • An analysis of nationally reported incidents revealed common themes. • The Shaping 'Our Future Quality Excellence Programme' would drive actions to reduce such incidents. • Electronic prescribing system implementation was expected to address issues raised by Health Inspectorate Wales (HIW) • Work was ongoing on prevention of future deaths and infection prevention/control, with electronic prescribing expected to help. • The Committee was focused on reducing incident prevalence and is not complacent. **People & Culture (click to view)** • A Staff story was shared about successful overseas recruitment and inclusion which was very well received. • There was a strong focus on workforce, savings, and financial management. • There was an ongoing review of training places and maintenance issues for doctors. • An emphasis was placed on psychological safety, culture, and the importance of speaking up, as demonstrated in Theatres. The Executive Director of People & Culture (EDPC) thanked the Chair (IMTS) for her leadership as chair. **The Board resolved that:** a) The Chairs Reports were **noted**.	
UHB 25/07/6.7	**Strategic Planning, Commissioning and Partnership Update (click to view)**	

The Strategic Planning, Commissioning and Partnership Update was received.

The EDF advised the Board that she would take the report as read and noted key areas of the report which included:

- The ongoing work to shift towards a longer-term strategic focus, ensuring each strategic objective and key driver of change was being addressed by relevant Executives and portfolio chairs. The process included regular updates and oversight to ensure all elements were moving in the right direction and on the right timescale.

- Annual Plan & Escalation: The annual plan's delivery challenges were acknowledged, especially in finance and performance. It was noted that the Board had been written to by the Cabinet Secretary and Head of NHS Wales, requiring a clear articulation of the current position and actions.

- Regional Planning: Work was underway to establish a new Joint Committee, with the first meeting scheduled for October 2025. It was noted that pre-work and patient engagement were ongoing, though some activities were delayed. Despite the delays, regional collaboration continued, particularly around the Llantrisant Health Park theatres, which were under review following a government-commissioned assurance report.

- Ophthalmology & Specialist Services: Updates were provided on ophthalmology priorities and the Velindre Centre. It was noted that the regional specialist services partnership with Swansea Bay was facing challenges, with some services now considered too fragile to sustain. Both Cardiff and Swansea were clarifying what services they could continue, aiming to set a precedent for managing unsustainable services.

- Velindre Cancer Centre: The opening of the Velindre satellite unit was noted as a positive development, with further updates on joint results and engagement activities.

- Engagement & Co-Production: There was ongoing work to ensure patient and community engagement in service planning, including targeted work with children and families to identify what worked and what did not.

Questions were raised about the tangible implementation of strategic plans, with the EDF confirming that detailed action plans were being developed with Clinical Boards.

The EDF advised the Board that there was a need to balance conceptual planning with actionable steps focusing on community and population health benefits.

The Executive Medical Director (EMD) highlighted efforts to involve university partners in delivery, using the joint academic Health Sciences partnership as a test case for future collaboration.

The UHB Vice Chair raised concerns about funding risks when Betsi Cadwaladr UHB were using North West providers, as Cardiff did not always receive equivalent funding for procedures.

The EDF acknowledged that it was a significant issue, especially for sustaining services at scale.

The CEO stressed the urgent need for a Wales-wide tertiary services strategy, noting ongoing lobbying and upcoming meetings with the Joint Commissioning Committee (JCC) Chief Executive. The complexity of service planning was discussed, including the influence of Cabinet Secretary directives and the need to balance regional and local service delivery.

	The Board agreed to note the progress made and recognised the need for ongoing development of detailed implementation plans, with a focus on community health and sustainable service models. **The Board resolved that:** a) The progress being made across the Strategic Planning, Commissioning and Partnership portfolio was noted	
UHB 25/07/6.9	**Monitoring the Annual Plan 2025/2026 (click to view)** The Monitoring the Annual Plan 2025/26 information was received. The EDF advised the Board that the paper outlined all of the multiple ways the the Health Board monitored the annual plan. She added that there had been an effort made to consolidate all monitoring methods for the annual plan into a single, coherent framework with the aim to clarify where and how each element was tracked, the frequency of monitoring, and how information was triangulated for assurance. It was noted that the planning Team was working to balance high-level summary with sufficient detail, ensuring that both the Integrated Delivery Report (IDR) and other documents reflected key priorities and areas needing more focus. **The Board resolved that:** a) The proposed monitoring arrangements for the 2025/26 Annual Plan as a proportionate approach for oversight and assurance was approved.	
UHB 25/07/6.10	**Integrated Performance Report (click to view)** The Integrated Performance Report was received. **Finance (click to view)** The EDF provided a brief update, noting ongoing financial challenges and referencing earlier, more detailed discussions around Finance. The Board acknowledged the pressures and the need for continued focus on financial performance. **Population Health (click to view):** The Executive Director of Public Health (EDPH) advised the Board she would take the paper as read and highlighted the key areas which included: • **Obesity:** The child measurement programme showed a slight improvement in healthy weight percentages, but a significant gap remained between the most and least deprived groups. Work continued through the Good Food and Movement Plan. • **Diabetes:** The Diabetes Strategic Programme Board was advancing foundational work, including health needs assessment, pathway mapping, and a focus on the eight primary care processes. A deep dive on diabetes was planned for the next Board development session. • **Vaccination:** The community model had improved vaccination rates, now above the Welsh average for most indicators. Measles remained a concern, with a back-to-school campaign planned. Staff vaccination uptake was being addressed through surveys and focus groups. • **Smoking:** 13% of the population still smoked; new methods were being explored to support quitting, with rapid health benefits highlighted. • **Women's Health:** Funding had been secured for a health needs assessment, waiting list review, and staff training. • **Health Protection:** An upcoming UK-wide pandemic preparedness exercise was noted.	

Operational (click to view):

The Chief Operational Officer (COO) advised the Board he would take the paper as read and noted that the Finance & Performance Committee had received a detailed update at the meeting held one week prior.

Key headlines included:

- **Urgent and emergency care** had been unexpectedly challenging, with summer pressures sometimes exceeding winter.
- **A&E and Ambulance waits:** Performance was stable but not improving; Cardiff remained the best in Wales for ambulance handovers but struggled to meet new 45-minute standards.
- **12-Hour Waits:** 8% of A&E patients waited over 12 hours, with 34 patients waiting over 24 hours in June 2025. Delays were mainly due to inpatient bed availability, not pathway-to-care delays.
- **Delayed Discharges:** Pathway-to-care delays were at their lowest, but medical specialties had high lengths of stay, especially after day 7. Reset weeks and targeted reviews were ongoing to address that.
- **Cancer:** Referrals were at their highest since August 2022, especially for skin cancer. Despite high demand, performance standards were being met or exceeded in most areas, with ongoing work in urology and breast cancer.
- **Planned Care:** The Health Board was on track to meet Welsh Government trajectories for long waits, with additional outpatient capacity being delivered through insourcing.
- **Diagnostics:** Significant progress in reducing non-obstetric ultrasound waits had been observed and endoscopy capacity was being addressed with new funding and mobile units.
- **Community & Mental Health:** Community capacity was increasing, but mental health demand remained high, especially for neurodevelopmental assessments. Funding uncertainties were impacting service delivery.

Discussion included the effectiveness of reset weeks, the need for efficiency over simply adding beds, and the importance of understanding root causes for delays. Outpatient transformation was identified as a key area for future focus.

People & Culture (click to view):

The Executive Director of People & Culture (EDPC) advised the Board she would take the paper as read and would highlight key areas.

- **Turnover:** Staff turnover was healthy (7–9%), with improvements in Healthcare Support Worker retention.
- **Agency/Bank:** Medical and nursing agency usage was down; focus was now on reducing bank usage and ensuring prudent care.
- **Job Planning:** Progress had been made toward 90% job planning compliance, with current rates at 75%.
- **Workforce Planning:** New SharePoint-based training was being rolled out to improve workforce planning capability.
- **Widening Access:** Engagement had started with local schools and communities and would be ongoing to support diversity and inclusion.
- **Staff Survey:** Preparations were underway for the next staff survey, with efforts to improve participation and feedback visibility.

Discussion focused on improving feedback loops from the staff survey and increasing Clinical Board ownership of actions. The Workforce Race Equality Standards report was noted as forthcoming and would be received by the Board at a later date.

Quality (click to view):

The END advised the Board that he would take the paper as read and would highlight key issues which included:

- **Patient Experience & Concerns –** a Slight improvement in closing concerns within 30 days (now at 69%) was observed.
  - The number of concerns received continued to exceed those closed, so monitoring continued.
  - **Inquests:** 342 were currently being managed, with a quiet summer but a significant increase in hearings expected in autumn.

- **Incidents & National Reportable Incidents (NRIs)**
  - 13 NRIs reported in June 2025, with recurring themes: deteriorating patients, lost to follow-up, and medication safety.
  - No never events reported in recent months, which was seen as a positive.
  - The organisation was focusing on using the Quality Excellence Programme to address those themes, with project groups established for targeted improvement.
  - Incident backlog (open over 30 days) stood at 2,075 and was monitored monthly at Executive level.

- **Infection Prevention & Control**
  - Bacteraemia rates were stable compared to previous years but not meeting Welsh Government reduction targets.
  - C. difficile rates were higher than previous years, which was a concern and targeted improvement work was underway as part of the Quality Excellence Programme.

- **Early Warning Scores & Digital Tools**
  - NEWS2 (adult early warning score) fully implemented, with lower escalation thresholds to catch deterioration earlier.
  - Paediatric and maternity early warning scores were being updated, with digital systems (e.g. BadgerNet for maternity) supporting rapid escalation and improved record-keeping.
  - The digital rollout was progressing well, with no major technical issues reported.

- **Sepsis**
  - The updated sepsis screening tool was now live across all areas, aiming to improve early identification and treatment.

- **Mental Capacity Act**
  - The medical workforce had lower compliance with Mental Capacity Act training; targeted work was underway to address that, including a dedicated meeting to improve compliance.

The Board emphasised the need for clearer reporting and learning from incidents, especially NRIs and never events, and for better communication of trends and actions taken.

Digital (click to view):

The Director of Digital & Health Intelligence (DDHI) advised the Board that he would take the report as read and summarise areas of importance which included:

- The Foundations Programme – it was noted that the programme was nearing completion of the programme business case after extensive engagement. The case would go through internal governance and was expected at Board in November 2025, with a major capital ask to Welsh Government anticipated.

	• Other highlights included rollout of the watch nursing care record, support for national digital programmes (e.g. radiology), and work to ensure system access for insourced staff. **The Board resolved that:** a) The year-to-date position against key organisational performance indicators for 2024-25 and the update against the Operational Plan programmes was noted.	
UHB 25/07/6.11	**Annual Plan Quarter 1 Update (click to view)** The Annual Plan Q1 Update was received. The EDF introduced a new format for the update, aiming to provide clarity on progress against strategic priorities, key delivery expectations, and the link between strategic and operational work. Feedback on the format was invited. She advised the Board that she would take the report as read and highlight key areas for noting: **Strategic Priorities** – it was noted the plan's focus was on "getting back to basics" and ensuring foundational improvements were delivered. It was noted that a summary table highlighted the main strategic priorities for the year—which were the actions considered essential to move the organisation forward. Progress updates were provided for each. **Finance & Key Delivery Expectations –** It was noted that the report included a brief update on the financial position (already discussed in detail earlier in the meeting) and outlined the key delivery expectations set by the Minister and Welsh Government. The EDF advised the board that those expectations were tracked, with updates on progress and any areas of concern. **Strategic Delivery Progress –** it was noted that it was the first year the Board was formally tracking strategic delivery alongside annual operational delivery Where concepts and plans were well-developed (e.g.104 and 52-week wait reductions), progress was strong and on track. The EDF noted that where plans were more conceptual at the start of the year (e.g. outpatient transformation), work was still in the development and scoping phase. **Measurement & Benefits –** The report noted that some actions had clear, tangible measures of success, while others were more enabling or preparatory in nature. The EDF advised the Board that there was ongoing work to clarify the benefits and outcomes expected from each action, and to ensure that preparatory work this year set up future delivery. **Workforce Planning –** The EDPC highlighted that strategic workforce planning capability was still developing and that the team was using new training and scenario-based modelling, focusing first on mental health, and working to improve the robustness of education commissioning and workforce supply modelling. The Independent Member – Local Authority (IMLA) raised a query about the clarity of the performance summary chart, asking for clearer explanation of red/green and data timing. The EDF acknowledged the query and noted that she would review the presentation for clarity.	

	The Board resolved that: a) The progress highlighted in the Q1 Annual Plan Report was noted.	
UHB 25/07/6.13	**Theatre Service Review Update (click to view)** The Theatre Service Review Update was received. The COO reminded the Board that in July 2025, the Theatre Together Programme presented an update to the Board, detailing the strides made since the comprehensive Theatre Review of 2024/25. He added that the review had unearthed several critical issues, including leadership failures, inconsistent policy adherence, and a detrimental culture that impacted staff behaviour and psychological safety. It was noted that since the last report, the programme had made significant progress and that meetings with Health Inspectorate Wales (HIW) had been fruitful, and the programme had even been referenced in the Cabinet Secretary's statements. The Theatre Together Programme was divided into two main phases: the Foundation Tranche and the High Impact Tranche. In the Foundation Tranche, several key achievements were noted. Access to the main theatres department had been reinstated for TDSI, the WHO checklist process had been standardised, paediatric recovery bays had been reviewed, and the staff room had undergone refurbishment. The High Impact Tranche had also seen positive developments. Initiatives such as safe space sessions for staff, staff engagement and recognition initiatives, and the appointment of a senior advisor to support theatres had been implemented. The COO emphasised that progress would be iterative, focusing on the most urgent recommendations first with the next update to provide detailed actions for all recommendations. He thanked his Team for the effort and commitment noting that taking 66 recommendations was no easy feat. The UHB Chair asked the COO to pass on his thanks on behalf of the Board for producing the report. The CEO asked how staff were feeling about the updates. The COO responded that the surgical Clinical Board would be holding open briefing sessions in September 2025. The IMLA asked the COO if there were any recommendations he was concerned about in terms of compliance. The COO responded that he had no concerns and noted that it was around managing time scales and that there was noting in the recommendations that could not be done. **The Board resolved that:** a) The progress on the Theatre Together Programme was noted.	
UHB 25/07/7.1	**Business Case - Transforming Access to Medicines (TRAMS) (click to view)** The TRAMS Business Case was received.	

	The EDF provided the Board with a brief outline of the case and noted that the Health Boards Radiopharmacy provision had been reducing because of the state of facilities. She added that the case aimed to improve the efficiency and equity of medicine distribution. Key points included: • **Fair Shares:** The financial principle ensured equity in the cost and benefits associated with TrAMs. It included a fixed contribution to cover the facility's running costs and a variable element for drug costs based on actual purchases. • There are concerns regarding the workforce transfer approach but the report highlighted the need to resolve issues related to the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) and the All-Wales Organisational Change Policy (OCP) before the Full Business Case (FBC) is finalised. • **Clinical Trials:** The importance and complexity of Clinical Trials production were acknowledged and a hybrid model for clinical trial preparation was being proposed, and further discussions were planned to finalise the delivery model before the FBC The Independent Member – Trade Union (IMTU) asked if there were any ideas on a timescale for the case. The EDF responded that it was an 18 month to two year timeframe and noted that securing the capital was the important piece required to progress. The IMTU added that he would connect with other Trade Unions to avoid any issues. The EMD concluded that the case appeared to be very complicated, particularly around the clinical trial part. He added that close collaborating with Velindre would be key. **The Board resolved that:** a) The TrAMs OBC, noting the required actions prior to FBC was approved.	
UHB 25/07/7.2	**Digital Transformation Review – Board Self-Assessment (click to view)** The Digital Transformation Review – Board Self-Assessment was received. The DDHI reminded the Board that Audit Wales was carrying out a review of Digital Transformation across all NHS Wales bodies. The objective of the audit was to understand and assess whether health organisations in Wales had the necessary arrangements in place to use and embed digital to improve the effectiveness and efficiency of services. He opened the conversation to the Executive and Independent Members who had completed the self-assessment. The Independent Member – ICT (IMICT) noted that it was a “mixed picture” with some of the comments highlighting that some Board Members were closer to digital than others. He asked what happened next. The DDHI responded that not all Board Members were sighted on the detail but noted that broadly speaking, everybody was supportive of digital transformation. He added that most Board members agreed that there were effective arrangements for identifying and managing digital strategy risks, and that oversight and assurance	

	mechanisms were in place, but also that there was less consensus on whether resources were fully committed across the digital transformation lifecycle. The UHB Chair asked if the Board was being asked to approve the self-assessment or if they were being asked to endorse the responses. The DDHI responded that the wording of the recommendation would be changed to reflect what the Board requirements were. **The Board resolved that:** a) The completed self – assessment document would be shared with Audit Wales	
UHB 25/07/7.3	**Emergency Planning Response Resilience Annual Plan (click to view)** The Emergency Planning Response Resilience (EPRR) Annual Plan was received. The COO advised the Board that the Health Board were on a journey to improvement on EPRR but noted that the organisation was not quite there yet. He added that work was underway to make EPRR more mainstream across the Health Board and noted that a quarterly report would be produced alongside the Director of Capital, Estates and Facilities for the Board to see. **The Board resolved that:** a) The response was approved	
UHB 25/07/7.4	**Committee Annual Reports (click to view)** **The Committee Annual Reports were received.** The IMCE noted that the reports captured the huge scope of work undertaken by the Committee but did not think they captured the collaboration between Committees so wanted to highlight that. **The Board resolved that:** a) The Annual Reports from the Committees of the Board were approved.	
UHB 25/07/7.5	**Declaring Accommodation Surplus (click to view)** The Declaring Accommodation Surplus item was received. The EDF positioned the paper noting that it outlined the progress made in relocating services from former residential blocks on the UHW site to alternative accommodations allowing for the closure and demolition of substandard buildings, reducing maintenance costs and improving facilities. It was noted that a planning application had been submitted for the initial phase, including the construction of additional car parking and a bus/transport hub. The EDF advised the Board that the Team were working with Clinical Boards to agree on suitable locations and timescales for the closure of Glamorgan House and Monmouth House. She added that on the other side of the UHW estate, a University Building was there and noted that Cardiff University had advised the Health Board of their intent to vacate the Tenovous Building, which would then be returned to the Health Board. The Independent Member – Finance (IMF) asked if the demolition work had been communicated effectively.	

	The EDF responded that all internal comms would go out (confirmed by the Director of Communications) and noted that the Health Board have been in active engagement with its neighbours on all sides of the UHW estate. **The Board resolved that:** a) The progress made to deliver the estate rationalisation programme was noted b) The declaration of Denbigh House, Carmarthen House, Brecknock House and the Sports & Social Club as surplus to requirements was approved c) The declaration of Glamorgan House and Monmouth House surplus to requirements subject to the satisfactory relocation of the services currently occupying the buildings was approved. d) The receipt of the Tenovous Building from CU and the declaration of the building as surplus to requirements was approved. e) The submission of a request to the Cabinet Secretary for Health and Social Care for the demolition of the buildings identified in (b), (c) and (d) above was approved. f) The recommendation to seek funding support from WG to progress the demolition, clearance of the site and construction of a grade car parking on the areas of the former residential blocks and a bus/transport hub on the land of the Sports and Social club was approved. g) The undertaking of a procurement exercise to appoint a suitable contractor to undertake the demolition works was noted. h) The submission of a planning application for the initial phase of the demolition works to include Brecknock House, Carmarthen House, Denbigh House and the Sports and Social club to include the construction of additional car parking capacity on the areas of the former residential blocks and a bus/transport hub on the land of the Sports and Social club was noted. i) The intention to submit a second planning application to include Glamorgan House, Monmouth House and the Tenovous Building when a timeline for vacant possession is determined was noted.	
UHB 25/07/8.1	**Corporate Risk Register (click to view)** The Corporate Risk Register was received. **The Board resolved that:** a) The Corporate Risk Register was **noted.**	
UHB 25/07/8.2	**Reports from Advisory Groups and Joint Committees** The Reports from Advisory Groups and Joint Committees were received. **The Board resolved that:** a) The Reports from Advisory Groups and Joint Committees were **noted**.	
UHB 25/07/8.3	**Committee, Advisory Group and Joint Committee Minutes:** The Committee, Advisory Group and Joint Committee Minutes were received. **The Board resolved that:** a) The Committee, Advisory Group and Joint Committee Minutes were **noted.**	
UHB 25/05/10.1	**Any Other Business**	
	Time & Date of the next Meeting: Thursday 25 September at 09:30am Woodland House, Coed Y Bwl	

ACTION LOG

Public Board Meeting

31 July 2025

MINUTE REF	SUBJECT	AGREED ACTION	DATE DUE	LEAD	STATUS / COMMENT
Actions					
UHB 25/07/6.6	**Chairs Reports from Committees of the Board**	Audit & Assurance Committee Chairs Report to be circulated to Board Members	25.09.2025	Director of Corporate Governance	**COMPLETE** Senior Corporate Governance Officer circulated to Board Members on 11.08.2025
UHB 25/07/6.10	**Integrated Performance Report (IPR): Population Health**	Health Protection – UK wide exercise happening over autumn. A report to be brought back to the Board or a Committee.	25.09.2025	Executive Director of Public Health	**IN PROGRESS** *(to be marked as COMPLETE once dates known and on Foward Plan)* Claire to provide update at meeting held 25.09.2025
UHB 25/07/6.10	**Integrated Performance Report: Quality**	A chart outlining Never Events specific to CAV required on the IPR	25.09.2025	Executive Nurse Director	**COMPLETE** Included on IPR moving forward (page 19 of this month's report)
UHB 25/07/6.10	**Integrated Performance Report: Digital**	Digital Foundations to be received by Board in November	25.09.2025	Director of Digital & Health Intelligence	**COMPLETE** On Forward Plan
UHB 25/07/6.13	**Theatre Service Review**	66 Actions/Recommendations to be circulated to Board members on Friday 1st August 2025	25.09.2025	Chief Operating Officer	**COMPLETE** Document circulated
Actions referred <u>TO</u> Committees of the Board/Board Development					
UHB 25/07/6.10	**Integrated Performance**	Workforce Race Equality Standard (WRES) to be received by the People & Culture *P&C) Committee in September and then brought to the Board via the	25.09.2025	Executive Director of People & Culture	**COMPLETE** On Forward Plan for October's P&C meeting and will be

	Report: People & Culture	Chairs Report from that Committee meeting.			included in Chairs Report to Board in November 2025.

Report Title:	**Chair's Report to Board**				Agenda Item no.	6.2	
Meeting:	**Public Board**	Public	X		Meeting Date:	**25 September 2025**	
		Private					
Status *(please tick one only):*	Assurance		Approval	X	Information		X
Lead Executive Title:	**Chair of the Board**						
Report Author (Title):	**Head of Corporate Governance**						

Main Report
Background and current situation:

1. **SITUATION/BACKGROUND**

This report aims to provide an update to the Board on relevant matters in my capacity as Chair of the Health Board, where I highlight key areas of activity including Board business and topical areas of interest.

2. **SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING**

2.1 Board and Committee Membership

A. I would like to express my thanks to John Union, Independent Member Finance who joins us for his last Board meeting today. John has been an extremely valued member of the board with his strong financial experience for the last 8 years and his willingness to support the Board fully during his term of office. He has readily taken on additional responsibilities to ensure the Board has fulfilled its commitments in a range of areas. We wish him every success in his future endeavours.

2.2 Board Development Session – 28 August 2025

During the Board Development session, the following items were discussed:

1. Finance Update – the parameters of plan for 2026-27 were reviewed
2. Strategy Planning Delivery Framework – discussion and overview
3. Integrated Performance Report - full review of performance
4. Impact of Prevention, through a Diabetes Lens

2.3 Diary Highlights since the last Board Meeting

Visit to Short Stay Surgical Unit – 13 August 2025

I spent some time in our Short Stay Surgical Unit (SSSU) in August and was delighted to see first-hand, how efficient the Unit was in spite of high levels of demand. Patients were cared for considerately and with kindness throughout.

I was also fortunate to witness some superb leadership and on-the-job training and development taking place between Sian (Supervisor) and Steph (Student Nurse) - pictured! Both colleagues automatically lived and delivered the values of Cardiff & Vale UHB. It was clear that Steph took responsibility for the work she was allocated and quickly built trust and an easy rapport with her patients. Her kind and caring approach quickly put patients at ease.

Sian used her considerable knowledge, experience and leadership skills to support, encourage and recognise Steph's good work - it was a pleasure to observe such effective team development. A big well done and thank you from me on behalf of the Board to you both and the overall team.

2.4 Leaders who Listen Implementation

As the Chief Executive set out in their last Board report that the Board have agreed a new model for the UHB for the *Leaders Who Listen* initiative which is actively shaping the leadership culture within the Health Board. It centers around refreshed patient safety walk rounds, designed to foster direct engagement between senior leaders and frontline staff.

Walkrounds – A Refreshed Approach:

The Patient Safety Walkround model, developed by the Institute for Healthcare Improvement (IHI), was designed to support senior healthcare leaders in engaging with frontline staff and demonstrating a visible commitment to a culture of safety

In Wales, Walkrounds were introduced in response to the findings of both the Francis and Andrews reports. In July 2025, the Cardiff and Vale University Health Board (UHB) approved a refreshed approach to delivering Walkrounds, embedding them within a broader Engagement and Assurance Framework.

This framework, titled "Leaders Who Listen", is structured around four tiers:

Leadership Listening Walkrounds

Executive and Independent Members of the Board will conduct monthly Walkrounds across both clinical and non-clinical areas. The primary focus of these Leadership Listening Walkrounds is to engage directly with staff, gaining insight into their experiences, successes, and challenges. These sessions provide a valuable opportunity for colleagues to share ideas and examples of good practice that can be celebrated and potentially scaled across the organisation.

Clinical Board Listening Walkrounds

As part of the Engagement and Assurance Framework, Clinical Board Listening Walkrounds will be introduced to strengthen strategic engagement between Clinical Boards and their services. These Walkrounds aim to provide Clinical Board leaders with the opportunity to hear directly from staff about their experiences, and to observe services from the perspective of patients, service users, and their visitors. This approach supports a deeper understanding of frontline realities and reinforces a culture of openness, learning, and continuous improvement.

Leading the Direction

"Leading the Direction" will incorporate the existing body of reviews, audits, and inspections carried out by expert specialist teams, including Infection Prevention and Control (IP&C), Nutrition Specialist Nurses, and others. This element of the framework will support a more strategic approach to designing a programme that not only provides assurance and drives improvement, but also informs the development of University Health Board (UHB) policy and strategy.

Leadership in Action

"Leadership in Action" incorporates self-assessment and audit activities, including the volume of inspections captured via Tendable. As part of the Engagement and Assurance Framework, this component will support a more strategic approach to self-assessment, with a focus on continuous improvement and the goal of achieving ward accreditation. It will also promote peer assessment, encouraging curiosity, collaboration, and the sharing of ideas and good practice across teams and services.

Leadership Listening walkrounds
Flexible leadership pairings—comprising one Executive and one Independent Member of the Board—will undertake monthly Walkrounds, with the potential to conduct up to ten visits each month. The Walkrounds commenced in August 2025, with four completed in the first month and a similar number scheduled for September.

Following each visit, the leadership pair documents the outcomes using Microsoft Forms. This information is then used to generate a follow-up email, sent on behalf of the pair, thanking the area for hosting the visit and providing personalised feedback that reflects the conversations held.

Feedback from the Leadership Listening Walkrounds will be analysed to identify emerging themes, which will be grouped under the Duty of Quality and the Health and Care Standards. A quarterly report will be produced and presented to the People and Culture Committee, and will also be included in the University Health Board's Quality Indicators Report.

Opportunities will be explored to share the outcomes of the Walkrounds more widely across the UHB through established communication channels, ensuring transparency, learning, and the celebration of good practice and encouraging clinical areas to extend invitations to the Board members to visit.

Clinical Board Listening Walkrounds
The second stage of the framework will be developed and published by November 2025 and will comprise a model of Walkrounds for the Clinical Boards to use to support engagements and ongoing quality improvements.

The model will be based on the Fifteen Steps, a quality improvement tool developed by NHS England to help healthcare teams understand what good care looks and feels like from a patient's perspective- starting from the moment they enter the clinical area. The initiative was inspired by a parent who said, "I can tell what kind of care my daughter is going to get within 15 steps of walking onto every new ward." This insight led to the development of a structured approach to capturing first impressions in healthcare settings.

The Clinical Board Listening Walkrounds will be observation based, prompt reflections and will generate feedback and discussion about what is working well and what are the challenges.

Leadership in Action and leading the Direction
The final two stages of the framework will be developed in early 2026 and an engagement and assurance framework document will be published at this time to support the Clinical Boards to develop their local engagement and assurance strategy.

The Leaders Who Listen engagement and assurance framework was co-produced with Executive and Independent members of the Board and Directors of Nursing following a board development day in July 2025.

The first stage of the framework, Leaders who Listen commenced in August 2025 with Walkrounds being undertaken by Executive and Independent members in four areas in the first month.

Feedback and communications arrangements are in place, and a quarterly report will be generated to support organisational learning.

The second stage of the framework, based on the NHS England tool "the Fifteen Steps" is under development and will be implemented from November 2025.

<u>2.5 Thank You</u>

As I Chair my last Board meeting, I wanted to take the opportunity to express my thanks to all of the Board. It has been an honour to be the Chair of the Health Board for the last 8 years, a role I have felt so immensely proud of, thoroughly enjoyed and I am sincerely grateful to have been given the opportunity to undertake.

Unfortunately, I will be leaving the Health Board during a financially challenging period – a scenario all too familiar within the wider public and private sectors across the UK.

I am confident colleagues in Cardiff and Vale University Health Board will rise to these challenges with professionalism and the Health Boards core values at the heart of everything , as we always do.

Finally, the most important thing is, to mention our amazing staff that we have working across the health board who have been magnificent in their constant endeavours to always provide high quality and compassionate care to our patients, their families and the wide range of communities we serve. I am so proud and so pleased to have had the opportunity to work alongside you all. I wish you all the best of luck and every success with the future.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 - Fixing the Common Seal/Chair's Action and other signed Documents since the last Board meeting

The **common seal** of the Health Board has been applied to **5** documents since as listed below;

Seal No.	Description of documents	Background Information
1120	Redlands GP Surgery Deed of Surrender from old lease	New 10-year lease between CAV and Francine Ferner, Nicholas Allen and Diana Duke
1121	Redlands GP Surgery Deed of Surrender from old lease	New 10-year lease between CAV and Francine Ferner, Nicholas Allen and Diana Duke
1122	Deed of Variation Pobl Homes staff accommodation at Llandough Hospital	1. In relation to the project agreement and definitions and interpretation agreement for the provision of staff accommodation
1123	Deed of Variation Pobl Homes staff accommodation at Llandough Hospital	2. Relating to staff accommodation at Llandough Hospital, Unit B1, B2, C and D Cwrt Llandough Penarth
1124	Lease of premises at University Hospital Llandough, Penlan Road, Penarth and University Hospital of Wales, Heath Park, Cardiff between Cardiff and Vale University Local Health Board (Landlord) and Welsh Ambulance Services NHS Trust (Tenant).	

The following **Legal Documents** are reported as having been signed on behalf of the Health Board;

Date Signed	Type of Document	Background Information
23.07.25	DC24029 – Jungle Ward Refurbishment refurbish the Jungle Ward located on the upper ground floor of Noah's Ark Children's Hospital for Wales. The adjacent wards will remain occupied during the works, necessitating careful planning around access and noise management.	
25.07.25	DC22099 UHW Drainage Phase 4 significant drainage issues across its three ward blocks due Phases 1–3 of the drainage replacement scheme were completed between 2023 and 2025. Phase 4 is now ready to proceed following the allocation of additional funding. o the narrowing of 42 drainage risers	

	from 4 inches to approximately 2 inches	
29.07.25	Redlands GP Surgery Deed of Surrender from old lease New 10-year lease between CAV and Francine Ferner, Nicholas Allen and Diana Duke	
13.09.25	Deed of Variation Pobl Homes staff accommodation at Llandough Hospital 1. In relation to the project agreement and definitions and interpreation agreement for the provision of staff accomodation 2. Relating to staff accommodation at Llandough Hospital, Unit B1, B2, C and D Cwrt Llandough Penarth	
05.09.2025	Lease of premises at University Hospital Llandough, Penlan Road, Penarth and University Hospital of Wales, Heath Park, Cardiff between Cardiff and Vale University Local Health Board (Landlord) and Welsh Ambulance Services NHS Trust (Tenant).	

The following **2 x <u>Chairs Actions</u>** have been taken on behalf of the Health Board; The Board is requested to ratify these decisions in accordance with Standing Orders;

Date Received	Chairs Actions Details	Background Information	Date Approved
08.08.25	Insourcing of Non-Obstetric Ultrasound Scanning	Insource non-obstetric ultrasound scanning services. The aim is to reduce waiting lists and address the backlog in diagnostic imaging by supplementing internal capacity with external support. The service will be delivered independently of existing staff, using high-quality equipment compatible with CVUHB systems. Total contract value £1,695,980.00	12.08.25
29.08.25	Insourcing of Endoscopy Procedures	The contract is for the insourcing of endoscopy procedures to support the delivery of appointments within the Endoscopy The contract will run from 4th September 2025 to 31st March 2026. The service aims to treat 2,668 patients during this period Total Value: £1,177,162.00 (VAT Exempt).	03.09.25

Recommendation:

The Board is requested to:

a) **NOTE** the report.
b) **APPROVE** the Chair's Actions undertaken.
c) **APPROVE** the application of the Health Board Seal and completion of the Agreements detailed within this report.

Link to Strategic Objectives of Shaping our Future Wellbeing: *https://shapingourfuturewellbeing.com/*			
Putting People First **Click the objective above to view more detail.**		Providing Outstanding Quality **Click the objective above to view more detail.**	
Delivering in the Right Places **Click the objective above to view more detail.**		Acting for the Future **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered *Please place an "X" in the below boxes as relevant*									
Prevention		Long term		Integration		Collaboration	X	Involvement	

Saunders,Nathan
21/09/2025 15:54:19

Protect Your Team. Protect Your Patients. Protect Yourself.

Get the flu vaccine.

"Our team is strongest when we're all protected. All colleagues should get the flu vaccine this winter."

Cardiff and Vale UHB Maternity Staff

Scan the QR code for a list of flu vaccination dates and locations for Cardiff and Vale UHB staff in 2025-26.

You can also visit SharePoint.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Mae Brechu yn achub bywydau
Vaccination saves lives

Report Title:	**Chief Executive's Report to Board**				Agenda Item no.	6.3
Meeting:	Public Board		Public	x	Meeting Date:	25 September 2025
			Private			
Status *(please tick one only):*	Assurance	X	Approval		Information	
Lead Executive:	Chief Executive					
Report Author (Title):	Head of Corproate Governance					

Main Report

1. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

To begin this report to the Board I would firstly like to extend my heartfelt thanks to Jan for his kindness, dedication, wisdom, and leadership that has shone throughout his tenure in the role of Chair of Cardiff and Vale University Health Board (CAVUHB). The depth of warmth felt across the organisation for Jan is testament to the strength of his personal values, visible leadership and commitment to the patients, colleagues and communities we serve. Thank you Jan for everything and all the very best for the future.

The expansion of the Targeted Intervention Escalation status was discussed at the last Board meeting. Since then, the draft escalation framework & key items for consideration have been received from Welsh Government (WG)/NHS Wales and discussed at a subsequent meeting with NHS Wales Performance and Improvement on the 11 August and subsequently at the Integrated Performance Delivery meeting on the 27 August. A detailed review for areas of focus were discussed at the Board Development session on the 28 August enabling a further conversation with WG/NHS Wales on the final version of the framework. The Board will be updated in due course. Whilst, the escalation framework is important, particularly in providing clarity on the requirements and criteria for de-escalation, it is not an outcome in and of itself. I can assure the Board that whilst the work to clarify the escalation framework is underway, work continues to be done to improve in the key areas of quality, saftey, governance, finance and performance as is demonstrated in the Integrated Performance and other detailed reports that will be received by the Board during the course of the meeting.

As previously discussed with the Board there is a need to consider substantive organisational change as a means to future sustainability and succssful delivery of the strategy. Following a thorough procurement process external expertise has been secured to work through a co-productive approach to design and test a refreshed organisational operating model, aligned structures and collaborations. This work is underway and deliverables include detailed reports, financial modeling, and an implementation roadmap, with evaluation based on strategic alignment, feasibility, engagement, productivity improvements, and implementation robustness. Key stakeholders and leaders from across the UHB will be fully involved and important in influencing the products and outcome . Board will be kept updated on progress as this work evolves.

The University Health Board has been subject to a prosecution by the South Wales Fire and Rescue Service (SWFRS) dating back to inspections carried out in Summer 2021 of a ward in Hafan y Coed Mental Health Unit. That prosecution concluded this month following agreement by SWFRS to amend their case from four charges to a single charge that we agreed to plead guilty to that our record keeping had been incomplete.

We felt throughout that the original charges did not adequately consider the difficulty that our colleagues working in what is an incredibly challenging environment, accentuated by the Covid pandemic, experienced and so it was right to defend the charges and our colleagues. The Judge concluded that the incomplete records did not translate to an increased risk to staff or patients and so awarded a fine of £25,000 and ordered costs be paid of £70,000.

We feel this is a proportionate outcome and it is important to note that in the interim period our safety standards and fire protocols have continued to improve and we enjoy a very positive relationship with SWFRS both in terms of our current fire safety processes and more broadly as we assist them with training venues.

The Health Secretary, Jeremy Miles, visited University Hospital Llandough Hospital to meet some of the patients benefitting from the increase in cataract activity earlier in the month. The Health Secretary was impressed with the improvement work that has been done and praised colleagues for their commitment and ongoing efforts to reduce long waiting times. The HB has reduced the number of ophthalmology pathways waiting more than 52 weeks by 34% in July 2025 compared to July 2024. Everyone involved was grateful for the opportunty to share their work with the Health Secretary and for his positive and encouraging feedback.

Strategic Objectives

- Putting People First

Staff Survey

Staff Survey Focus Groups are now established as a key forum for colleagues to share experiences, shape improvements, and engage directly with Trade Union Partners, the People & Culture team and myself.

The next focus group will share progress within clinical boards since the last survey and show the “so what”, the tangible actions taken in response to staff feedback. This will help build confidence in the process and encourage greater participation in the next survey which launches on the 6 October.

I want to take a moment to emphasise how vital colleague’s voices are in shaping the future of the organisation. Last year’s survey provided valuable insights and this year we are building on that momentum. This 2025 survey aligns with broader strategic goals, including commitment to a transformed and stable workforce, enhanced digitalisation, and creating a great place to work. I encourage all colleagues to take the time to complete the Staff Survey. Your feedback will help us continue to improve and innovate alongside making the HB a better place to train and work

Flu vaccination Campaign 2025-26

The Public Health Team have commenced the roll out of the winter flu vaccine from 1 September. All Health Board Staff are eligible for vaccination*. Colleagues can get their vaccine by visiting the vaccination clinics organised in all the HB main sites, details of which are available online Flu vaccination for CAVUHB colleagues - Cardiff and Vale University Health Board, there is no need to book.

We all play a vital role in protecting the health of patients, colleagues, and the wider community. With flu season approaching, getting your flu vaccination is the most effective way to keep everyone safe and build organisational resilience. I urge all colleagues to take up the offer of a flu vaccination. We are absolutely committed to giving **everyone** in the team the opportunity to get vaccinated and have agreed that everyone is entitled to 30 minutes of protected time to do this. Managers have a responsibility to support their team' resilience and health and wellbeing and must facilitate this support. Vaccines will be provided directly on the wards with roaming teams conducting immunisations "in place".

The influenza vaccine is a safe and effective way to protect yourself, your patients and your family and make sure teams are fully staffed and healthy at the peak of the seasonal influenza epidemic.

*Colleagues over 65 or who are immunosuppressed: guidelines recommend vaccination from the 1st of October 2025 to make sure immunity does not wane before the peak of the epidemic. Relevant members of the team will be asked to access vaccination in October.

Local Partnership Forum (LPF) Collaboration

The Local Partnership Forum (LPF) is a cornerstone of organisational collaboration, providing a vital space where staff representatives and management come together to discuss issues, surface challenges and shape the future of the organisation.

The LPF meets regularly throughout the year and is the vehicle for much of the partnership working between the Executive Team and Trades Unions. It is also an important part of how the HB demonstrates compliance with social partnership, including the Social Partnership Duty which requires public bodies to seek consensus or compromise with Trades Unions when setting wellbeing objectives as well as requiring socially responsible procurement duties to ensure that the Welsh public sector spending supports fair work and wellbeing. You can read more about social partnership and the Welsh Way here: Social Partnership The Welsh Way

The Board can be assured that the executive and senior leaders across the organisation recognise the requirements of social partnership and are active in their engagement and where challenges exist are open to dialogue and collaboration in seeking solutions.

- Providing Oustanding Quality

Urgent and Emergency Care Performance Improvement Matrix Recognition

It was great to see that the UHB has been commended for Whole-System Accountability and Leadership by NHS Wales Performance and Improvement. In its recent Urgent and Emergency Care Performance Improvement Matrix, NHS Wales Performance and Improvement highlighted Cardiff and Vale UHB as an area of good practice. Aiming to share learning and encourage improvement across Wales, the

UHB has been identified as the benchmark for sustaining whole-system accountability and strong leadership in urgent and emergency care.

As part of the Six Goals for Urgent and Emergency Care, we were the first organisation in Wales to successfully implement organisational 'red lines', or non-negotiables, into the urgent and emergency care system, robustly overseen by the Executive Team.

As a result, we have achieved:

- A significant reduction in the number of hours lost to delayed ambulance handovers
- A zero-tolerance approach to ambulance waits of over two hours for handover
- A reduction in the number of patients held over 12 hours in the Emergency Unit, with University Hospital of Wales delivering consistently better 12-hour performance than the NHS Wales average over the last two years.

The Matrix also highlighted that we have been early adopters of placing a senior decision-maker at the front door, enabling early identification of patients who are seriously unwell and require escalation, as well as those who can receive urgent treatment in an alternative department.

I am extremely proud that the team have won this deserved recognition, none of this would have been possible without the dedication and support of the team in the Emergency Unit. This also demonstrates excellent collaborative working across the whole UHB and the teams' sustained efforts in driving these improvements forward. I would like to thank all colleagues for the great work to improve the emergency and urgent care services. We recognise that there is still more to do, but the progress made so far is a testament to colleagues' commitment to supporting patients in accessing the right care, first time.

Winter Planning

As we approach the winter months, the UHB is taking proactive steps to ensure we are well-prepared to meet the seasonal challenges ahead. Winter brings increased demand across urgent and emergency care services, and this year is projected to be the busiest yet, with daily attendances at the Emergency Unit expected to reach 450 patients.

The winter planning is built around three key priorities:

- **Building community capacity** to support care closer to home and reduce avoidable admissions
- **Maximising hospital capacity**, both acute and community, to ensure we can respond flexibly to surges in demand
- **Optimising patient flow** through a "home first" approach, enabling timely discharge and continuity of care.

We are implementing targeted improvements across the system and working closely with partners in local government and primary care to mitigate pressures and maintain safe, high-quality care for patients in readiness for the winter period. Further updates will be shared with the Board as the Plan progresses.

Improvement Work

Board has previously been briefed on cultural and improvement work being conducted across the UHB. The need for this work can be driven through a range of factors or collection of factors, such as poor team dynamics or behaviors, variable quality outcome concerns, patient or staff safety reports or incidents, staff or patient

survey feedback or complaints and formal reporting mechanisms such as Datix or Speak Up Safely.

Some improvement work is driven by a need to strengthen productivity and efficiency leading to better activity related performance and some by a need to modernise or introduce novel therapies, digitisatiion or ways of working.

There is improvement work underway in many teams and departments right across the organisation including but not exclusively, theatres, ophthalmology, cardiology, the Artificial Limb Service and Mental Health.

The range and number of improvement initiatives underway is a good sign and indicative of an organisation with an increasingly open culture, an appetite for continuous learning and a growing depth of expertise in improvement methodology and part of the work to embed a robust Quality Management System.

- Acting for the Future

Education and Training Commissioning Health Education Improvement Wales (HEIW)

I was pleased to attend the UHB's annual Education & Training Commissioning meeting with HEIW in August, alongside other members of the Executive Team. The meeting creates the opportunity to receive feedback from HEIW, as the commissioner, on the quality and effectiveness of the education and training provided to learners across the healthcare professions by the UHB. It seeks to establish assurance that the meeting of quality standards, regulatory requirements, financial stewardship, and innovation priorities are being met.

It was great to hear that there has been a positive "step change" in the rate of improvement in meeting HEIWs expectations. Particularly in relation to

- the establishment of a monthly Resident Doctors' Forum
- work in relation to Speaking up Safely including hosting an Away Day for Resident Doctor Forum representatives and developing a stand-alone course
- a fully embedded online corporate induction across the Health Board
- a comprehensive and robust, quality management and risk register process
- increased number of Clinical Teaching Fellow posts across the Health Board and received many high-quality applications
- reorganised the delivery of simulation training for Foundation doctors to facilitate attendance.

Quite rightly there are also areas for improvement covering the continued strengthening of educational and governance structures, widening access to educational opportunities for Locally Employed Doctors and developing training opportunities across the Health Board for trainers and resident doctors, particularly to support individuals through the transition points.

- Delivering in the Right Places

BadgerNet - Maternity Electronic Health Records

Cardiff and Vale University Health Board has introduced a new digital system to make accessing maternity records, care plans and important information easier and more convenient. On the 29 July 2025, the UHB launched the BadgerNet Maternity System, an electronic health record system that allows midwives, consultants and healthcare

professionals in hospital and community settings to update maternity records in real-time.

The Health Board also introduced the Badger Notes app and online portal on Tuesday 29th July, meaning pregnant women and healthcare professionals involved in their care will have real-time access to their maternity records.

Badger Notes will enable pregnant women to access their maternity records, important information such as upcoming appointments and birth plans, and insights into their baby's development on their computer, tablet or phone. Women will also be able to contribute to their own record, and anything added can be discussed at their next antenatal appointment.

For the team, the system reduces duplication, improves communication between teams, and ensures that the most up-to-date information is always available wherever care is provided, in hospital, the community, or at home. This means more time can be focused on providing care rather than completing paperwork.

I am delighted to see this implementation which highlights the importance of digital transformation to modernise maternity services and enhance data integration both internally and with stakeholders in the community to ensure care delivery is effective, efficient and safe.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

The Board will be aware of the current and on-going challenges to the financial position. The current forecast of £56.2 million continues to be under pressure through a combination of a shortfall in the savings programme and some operational pressures and risks. The Executive Director of Finance will give a detailed update and the detailed figures later in the meeting. Nevertheless, the commitment to the current forecast remains and significant work is underway to de-risk that achievement. This has included financial deep dive sessions held with all Clinical Boards throughout September. These sessions are critical to driving delivery against the control totals and identifying opportunities for both in-year and recurrent savings.

As we approach the winter period, there is a real risk of a challenging autumn due to the projected demand on urgent and emergency care services and with that comes the consequential impact on quality & safety, expenditure, patient experience and the health and wellbeing of the team. Board will be kept updated on any emerging risks as we move into the winter period.

Appendices

- Appendix 1- Staff Winter Flu Vaccination poster

Recommendations

The Board are requested to:

NOTE the Strategic Overview and Key Executive Activity to provide assurance described in this report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

Putting People First		Providing Outstanding Quality	
Delivering in the Right Places		Acting for the Future	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/ Exec	Date:

Report Title:	Finance & Performance – Chair's Report				Agenda Item no.	6.4	
Meeting:	Board		Public	x	Meeting Date:	25.09.2025	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Corporate Governance Officer						

Main Report
Background and current situation:

The purpose of this report is to highlight the key issues which were raised and discussed at the Finance and Performance Committee meeting held on the 23rd July 2025

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The Committee considered several important items of business at the meetings and a brief synopsis of some of the items discussed are set out in this Report.

Financial Report – Month 5 (including savings tracker)
The following points were highlighted under the Financial Report:

- A £27.8m deficit was reported at month 5, £4.4m over plan. Key drivers: savings shortfall, operational pressures, mental health out-of-area placements, underperformance in cardiac contracts, and a £1m GP out-of-hours pay provision.
- Deep dives with clinical boards were held; some boards have plans to recover, but gaps remain, especially in specialist services and children/women's services. A vacancy freeze is being implemented as a further control.
- Welsh Government has made clear the £56.2m planned deficit is a minimum and must be met; no additional support is expected.
- Risks include the band 2-3 corrective payments (not in current figures), underlying deficit, and cash management.

Operational Performance Report
The following points were highlighted under the operational performance report:

- Emergency department attendances remain high, but 12-hour waits and ambulance handover delays had improved.
- Stroke pathway performance improved; delayed transfers of care remain a challenge, with most delays attributable to social care or joint health/social care issues.
- Cancer pathway performance is best in NHS Wales, but backlogs in skin and urology are growing. Long waits for outpatient appointments are reducing, and the health board is on track to meet Welsh Government targets for reducing long waits.
- Diagnostics: Some deterioration in ultrasound, MRI, and CT due to staffing and equipment issues, but recovery plans are in place.
- Neurodevelopmental waiting lists for children remain high, with waits over three years; the model is being reviewed with Welsh Government.
- Productivity and efficiency: Some improvements, but outpatient DNA rates remain high.

Long-Term Financial Sustainability

- A proposal was presented to align long-term financial modelling with the clinical services plan, aiming for a more strategic approach to financial planning. The committee supported the approach, with suggestions to include outcomes, return on investment, and external dependencies.

Business Case: Llantrisant Health Park Diagnostic Hub

- The outline business case was presented for a regional diagnostic hub at Llantrisant, led by Cwm Taf Morgannwg. The committee supported the case in principle, noting risks around revenue funding, workforce, and the need for ongoing regional engagement. The recommendation to board will include the need for revenue assurance.

Monitoring returns for months 3 and 4 were noted.

The next meeting will be chaired by Rhian Thomas (Independent Member, Capital, Estates & Facilities), as John Union is leaving CAV UHB at the end of September 2025. John was thanked for his service.

The Board is requested to:

a) **Note** the contents of the Report.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
Putting People First 1. Click the objective above to view more detail.	x	2. Providing Outstanding Quality Click the objective above to view more detail.	x
Delivering in the Right Places 3. Click the objective above to view more detail.	x	4. Acting for the Future Click the objective above to view more detail.	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Board Assurance Framework				Agenda Item no.	6.5	
Meeting:	Board		Public	X	Meeting Date:	25 September 2025	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive Title:	Director of Corporate Governance						
Report Author (Title):	Director of Corporate Governance						

Main Report
Background and current situation:

The Board Assurance Framework (BAF) provides the Board with information on the key Strategic Risks that could impact upon the delivery of the Health Board's Strategy. It comprises 6 risk themes that are applicable to every one of the 4 strategic objectives.

The 2 delivery focused risk themes are:

1. Quality
2. Health Equity

And there are 4 key enabling risk themes:

3. People
4. Digital
5. Infrastructure
6. Sustainability

While each risk theme is relevant to every strategic objective, they are connected both with a strategic portfolio and a Committee of the Board to provide an appropriate thread from the strategy through delivery and into performance, and a means of assurance and scrutiny through Committees and into Board.

Executive Director Opinion and Key Issues to bring to the attention of the Board:

As is routine, all changes (bar the trend graphs) are shown as track changes.

There have been no changes to overall net risk scores.

The BAF has now appeared or is on the forward plan for all relevant committees. As a reminder these are:

Risk Theme	**Committee**
Quality	Quality
Health Equity	Quality
People	People and Culture
Digital	Digital and Infrastructure
Infrastructure	Digital and Infrastructure
Sustainability	Finance and Performance

Updates

- The MH service review work is reflected in the Quality actions.
- Vaccination factors have been captured in Health Equity.

- The Digital Foundations Business Case has been completed and will appear at Nov Board prior to WG submission.
- A number of updates regarding decarbonisation and climate are within the sustainability risk theme.

Assurance is provided by:

- Discussion with Executive Directors on progress being made against the management and mitigation of risks which they lead upon on the BAF.
- Discussion at the various Committees of the Board on the risks allocated to them for review.
- The strategic portfolio work being led by Executives.

Recommendation:

The Board is requested to:

- **Review and note** the risk themes regarding the delivery of Strategic Objectives detailed on the attached BAF.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please place an "X" in the below boxes as relevant.*			
1. Putting People First **Click the objective above to view more detail.**	X	2. Providing Outstanding Quality **Click the objective above to view more detail.**	X
3. Delivering in the Right Places **Click the objective above to view more detail.**	X	4. Acting for the Future **Click the objective above to view more detail.**	X

Five Ways of Working (Sustainable Development Principles) considered *Please place an "**X**" in the below boxes as relevant*									
Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Quality Impact Assessment Completed?: *Please place an "**X**" in the below boxes as relevant. A blank QIA and guidance on how to complete a QIA can be found by clicking the link here:* ***Quality Impact Assessment Information***				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***	X	There is no impact on the Duty of Quality

Impact Assessment: *Please state **yes** or **no** for each category.* ***If yes please provide further details.***
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No

Socio Economic: No - *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES*
Equality and Health: No - *Useful guidance on the completion of an EHIA can be found at the following link: EHIA toolkit - Cardiff and Vale University Health Board (nhs.wales)*
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	

Shaping Our Future Wellbeing

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Board Assurance Framework

Updated 25 Sep 25

Introduction

The Board Assurance Framework (BAF) is the tool and document that seeks to articulate what strategic risks an organisation has identified that will, if not addressed, prevent it from delivering its strategy.

There is no definitive format, and it is intended that the below pages present in as clear a manner as possible the alignment between CAVUHB's 4 strategic objectives, the strategic portfolios that are led by the Executives in order to turn the strategy into delivery over the course of the strategy, the strategic risks that have been defined to best articulate the major themes that could prevent the delivery of the strategy, and the Board's Committees that are charged with seeking assurance on and scrutinising the delivery of each strategic objective.

While each strategic risk aligns to a Committee, the risks themselves are applicable to all 4 strategic objectives and have a whole organisation perspective and impact. Each has a risk appetite as determined by the Board.

Each risk seeks to identify the potential cause and effect of a manifestation of the risk becoming an issue. This 'uncontrolled' assessment makes use of a simple 5 x 5 scoring guide for likelihood against impact:

Likelihood / Impact	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Severe (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Moderate (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare (1)	1	2	3	4	5

Each risk is then assessed for the different controls and assurance measures or mechanisms that are in place, as well as identifying where there may be gaps in these facets. Once these have been applied a new assessment, using the above scoring system again, is then made.

However, the BAF is not a definitive mechanism or science. It is a vehicle for the organisation to articulate and expose some of the strategic level impacts on delivering the strategy, and for the Board and Committees to pull through and scrutinise those elements that are appropriate.

Finally, the BAF seeks to articulate the activity taking place relevant to each risk for assurance.

This document looks to capture and present this information so that the Board and members of the public can see all of the above information, the trends in scoring, the actions being undertaken and every change made to the document between one Board meeting and the next through the use of track changes.

Shaping Our Future Wellbeing

Strategic Framework

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Strategic Framework						
Strategy	**Putting People First**	**Providing Outstanding Quality**			**Delivering in the Right Places**	**Acting for the Future**
Strategic Portfolio	Shaping Our Future People & Culture	Shaping Our Future Population Health & Place Based Partnerships	Shaping Our Future Quality, Value & Sustainability	Shaping Our Future Clinical Services	Shaping Our Future Infrastructure	Shaping Our Future Generations
Strategic Risk Theme	People	Quality			Digital	Sustainability
		Health Equity			Infrastructure	
Committees	People and Culture Committee	Quality Committee			Digital and Infrastructure Committee	Finance and Performance Committee
		Mental Health Committee				
	Audit & Assurance					

Shaping Our Future Wellbeing

Strategic Objectives

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

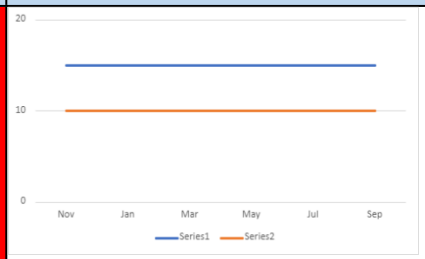
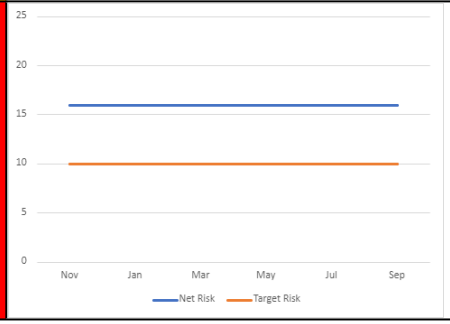
Strategic Objectives			
Putting People First	**Providing Outstanding Quality**	**Delivering in the Right Places**	**Acting for the Future**
We will be a great place to train, work and live, where we listen to and empower people to live healthy lives. By 2035, colleagues would recommend us a great place to work, our workforce will reflect the diversity of our communities and more people will be living healthier lives.	We will provide outstanding services which are equitable, timely and safe, where people are treated with kindness and are supported to achieve the outcomes that matter to them. We will have reduced inequities in prevention, improved access to clinical services and clinical outcomes.	By 2035 we will be using real time integrated data to inform joint decision making and multi-disciplinary team working, giving people access to and ownership of their data to enable them to manage their health and wellbeing. We will be well on our journey to provide care in the right place, in facilities that are fit for purpose, flexible and promote recovery.	We will work to ensure that what we do today does not compromise the wellbeing of our future generations. We will protect the environment and develop and use new technologies, treatments and techniques to provide the best possible health outcomes and sustainable health care into the future. By 2030 we will have reduced the Health Board's carbon footprint by 34% and will have increased our research and clinical innovation activities.
People will feel valued, developed, supported and engaged. We will have an inclusive culture where the diversity of the Health Board's people will be representative of the Health Board's local populations. Through our integrated population health improvement programme, we will enable and empower people to live healthy lives and reduce their risk of ill health.	Focus on minimising inequity in healthy behaviours, preventative services, access to clinical services, and health outcomes, to reduce current unfair, unjust differences experienced by people in the community Deliver outstanding quality of care every time - from the most complex care for the most critically ill to routine care that prevents and protects against ill health and disease – addressing physical and mental health needs. Achieve the best outcomes for patients in line with what matters most to them, their families and carers. Develop the Health Board's approach to continuous quality to improvement and make the best use of the Health Board's resources.	To achieve digital maturity enabling the Health Board to connect and communicate, supporting shared decision making in the planning and delivery of health care services. Refresh and deliver the Health Board's programme for creating integrated health and care facilities in our local communities where people can access the information and support they need under one roof. With Cardiff University and NHS partners, develop the Health Board's plans for ensuring hospitals providing acute care are fit for the future. Develop more shared infrastructure with public and private sector partners to get best value for the Health Board's investment.	Develop and expand the Health Board's research, teaching and innovation portfolios in collaboration with Cardiff University and other partners. Contribute to the development of and adopt cutting-edge and novel treatment, techniques and technologies where they deliver improved patient outcomes and improved value. Maximise the Health Board's contribution to the foundational economy Deliver the Health Board's carbon emissions targets and fully support active and sustainable travel for staff and visitors to patients. Promote, reward and embed successful waste reduction as part of our quality programme of continuous improvement.

Shaping Our Future Wellbeing

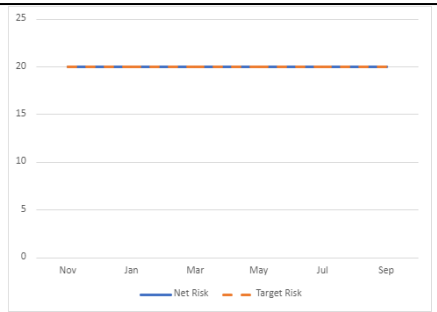
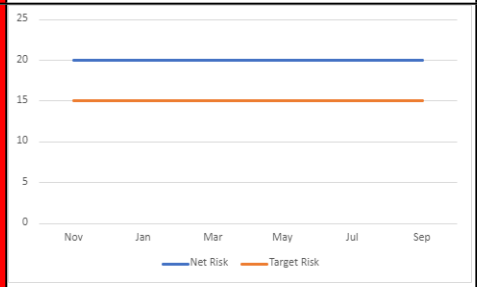
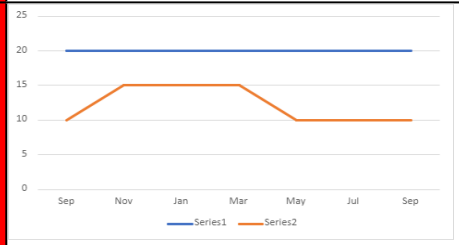
Strategic Risks – Quality

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

What will prevent Cardiff and Vale University Health Board from delivering its strategy?
If any of the below risk themes cannot be controlled, then the strategic objectives are unlikely to be met.

Strategic Risk	Risk Appetite / Target Risk	Gross Risk *(no controls)*	Net Risk *(after controls)*	Trend	Context	Executive Lead(s)
Quality	Cautious 10	25	15		Our ultimate priority - to continuously, reliably, and sustainably meeting the needs of the population that we serve. Our organisation will focus on delivering assurance on the six domains of quality with the ultimate aim of providing outstanding care to our patients. We will strive to deliver Safe; Timely; Effective; Efficient; Equitable and Person-Centred Care.	Exec Dir Nursing Exec Medical Dir Exec Dir AHPs and Health Science Chief Operating Officer
Health Equity	Open 12	16	12		One of our two statutory responsibilities as a Health Board is to improve the health and well-being of our local population. The overall aim of our strategy is: 'Working together, we will help improve lives so that by 2035 people are healthier and unfair differences in health outcomes are reduced.' The goal is to improve health outcomes by reducing inequity in indicators of healthy behaviours and increasing the use of preventative services and access to clinical services.	Exec Dir Public Health
People	Open 10	20	16		The most important asset of any organisation. Through the delivery of the People and Culture Plan, our strategy will be delivered with a key focus on these core People risks: Attract, Recruit, Retain | Culture | Wellbeing	Exec Dir People

Strategic Risks – Quality

Digital	Cautious 20	25	20		Data is integral to our strategy. It empowers informed decision making about what we need to do, why, when and how we perform. Delivering our digital and data transformation road map will introduce actionable insights and capabilities that enable clinicians and patients in any setting delivery of safe, high-quality care, improving productivity, efficiency and communication through person centric digital solutions. The security, management and accessibility of data is essential.	Dir Digital
Infrastructure	Open 15	25	20		The Health Board has the largest hospital in Wales, a footprint across dozens of locations and integrated service locations with key partners. We must shape our future infrastructure to ensure facilities are fit for the delivery of modern healthcare, intelligent integration takes place with partners and the service is delivered in the right locations for our population.	Exec Dir Finance
Sustainability	Cautious 10	25	20		Sustainable, efficient services are a legal requirement, improve quality and ensure a sustainability of service for now and future generations. By articulating the strategy through the integrated mid-term plan and the proper alignment of resources and consideration of the environment the Health Board will meet its statutory duty and ensure value in delivery.	Exec Dir Finance

Risk Appetite			
Avoid	Avoidance of risk and uncertainty is a key organisation objective	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (VFM)
Minimal	Preference for ultra-safe delivery options which have a low degree of inherent risk and only for limited reward potential	Seek	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential reward	Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

Strategic Risks – Quality

Strategic Risk	Strategic Portfolio	Exec Leads	Committee	Date Added
Quality	Shaping our Quality, Value & Sustainability	Exec Dir Nursing | Exec Medical Dir | Chief Operating Officer Exec Dir Therapies and Health Science	Quality	30 Sep 24

Risk

Delivering outstanding quality and eliminating avoidable harm is the ultimate priority of the Health Board, however, constraints associated with capacity,
Capacity, governance and leadership to deliver measurable success across each of the six domains of quality impacts on the ability to deliver quality all the time and for the entire population

Cause

Safe – avoiding harm to service users and staff
Risk to delivering safe care is increased due to demand pressures, workforce shortages, aging physical estate, lack of digital technology and variation across the organisation.

Timely – providing care within an appropriate timescale to avoid harmful delays
Ability to deliver timely care is significantly impacted by the backlog of referrals following the covid-19 pandemic and the mismatch between demand and recurrent capacity within many clinical services

Effective - providing services based on scientific evidence and refrain from providing treatments and services that do not benefit patients
Ability to deliver effective care is impacted by workforce pressures, outdated systems and process, particularly related to digital technology, clinical coding and aging physical environments. The challenge in accessing real time data to track care against a robust evidence base means that the organisation is dependent on retrospective data to inform its response to quality risk

Efficient - avoiding waste that does not add value to the patient or the desired outcome
Risk to delivering efficient care is caused by outdated systems and process, particularly related to digital technology and aging physical environments and workforce efficiency

Person Centred - providing care that is respectful and responsive to patient's values and needs
In order to reduce the risk of not delivering person centred care the organisation must seek understanding of our population, empower patients, seek options to receive feedback and develop a responsive culture.

Equitable - Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life
We embed equality and human rights in our health care system.

Impact

Safe
The UHB continues to see a number of same cause patient safety incidents, complaints, redress cases and claims where the harm to patients is potentially avoidable. These include health care associated infections, failure to ensure continuity in clinical pathways, failure to recognise the deteriorating patient, failure to escalate, issues with communication and Never Events. The health, safety and welfare of our staff is not universally maintained.

Timely
Long waiting times for planned care and diagnostics means care is delivered at inappropriate timescales with a potential consequence of progression of disease, worsening wellbeing and associated psychosocial impact on patients and families. Care is ultimately costlier to provide.

Effective
Benchmarked data associated with national clinical audits demonstrates that we don't universally benchmark in the top 30% of organisations nationally for performance and outcomes. The pressure on estates, workforce capacity and wellbeing will impact on our ability to provide care in line with evidence base.

Efficient
The Health Board is not meeting some of its productivity and efficiency ambitions, including in relation to outpatients and length of stay. Care may be being delivered which does not provide value to the patient, wider population and health economy. Care can be duplicative and wasteful. Care is often delivered with a disproportionate focus on intervention vs prevention. Constraints around workforce availability results in a reliance on non UHB staff to provide core.

Person Centred
The Health Board is striving to deliver care that meets the patients right to empathy, compassion, privacy, dignity and respect. In some areas patient experience is below our ambition, for example in the Emergency Department which is below the 85% target in all but one measure. The Health Board is seeking to ensure patients and families views are sought and play a role in improving services.

Strategic Risks – Quality

We design services that meet the needs of our local population.		**Equitable –** Our health outcomes between different population groups (e.g. most deprived and least deprived and different ethnic groups indicate that we have more work to do on this aspect of quality. We have developed an 'Equity, Equality and Patient Safety Framework for the Health Board' this describes a framework for change, provides examples of best practice from across the world, and finally outlines the key actions each Clinical Board has committed to. For example, our data collection of protected characteristics is poor, and each Clinical Board will need to make improvements in this area. Using a co-production approach supports equity.	
Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 10

Controls	Assurances
Safe – Corporate Quality and Safety team have oversight of all UHB patient safety incidence, the Duty of Candour supports systematic scrutiny of all incidents reported as having caused moderate harm and above. Quality Committee and the groups that report into the committee provide oversight of emerging trends. The clinical safety group brings together the clinical boards and clinical advisory groups to support the development of strategy and policy to deliver quality aligned to current risk. The Shaping our Future Quality Excellence Programme is designed to address emerging patient safety themes. The Theatres Together programme is overseeing improving work in theatres that has emerged from the recent theatres review. **Timely**- Planned Care programme and Operational Performance meetings delivering on plans to reduce waiting times. Patients prioritised in line with Health Board criteria – Urgent and Emergency Care; Cancer and Time-Critical; planned (in referral order). Recovery plans are in place for diagnostic long waits such as endoscopy and non-obstetric ultrasound. **Effective –** The Clinical Effectiveness Committee provides oversight of national clinical audit outcomes and improvements and implementation of NICE and HW guidance. Clinical Boards are bringing an overview of their local arrangements to providing continuous focus of national audit data and use it to transform clinical pathways as has been done in stroke and hip fracture. Work is planned as part of the Sharping our Future Quality Excellence – Quality Management System Project to standardise the collection of national audit data and to embed it into quality governance structures. **Efficient –** operational programmes in planned care and urgent and emergency care focused on delivering best practice. Benchmarking and use of GIRFT central to programme. Productivity and Efficiency ambitions in place and monitored. **Person Centred –** Value Based Healthcare programme supporting projects and programmes focused on delivering value to patients. The UHB is rolling out a new PROM platform "Promptly" throughout the organisation to provide reliable opportunities to collect this information.	• Clinical Board Performance Meetings • Integrated Performance Report • QSE • Clinical Effectiveness Committee • Clinical Safety Group • Risk registers • Executive Reviews • People and communities experience framework • CIVICA • Benchmarking Information (Clinical) • Get It Right First Time • Peer Reviews • HIW and external assurance • PSOW REPORTS • WRP assessments • Accessibility standards • Equity, Equality, Experience and Patient Safety Framework and Action Plan at Quality Committee • Assurance of CAVHIS Business Case Implementation in 2024/25

Strategic Risks – Quality

Equitable – We monitor performance against the actions outlined in the Equity, Experience and Patient Safety Framework and Action Plan. This goes to Quality Committee every six months. Our Cardiff and Vale Health Inclusion Service (CAVHIS) supports the most vulnerable people experiencing 'cliff edge' health inequalities, but there is more to do to support this population and reach out to the next level of people experiencing health inequalities. Investment has been agreed to support this expansion. Implementation of this Business Case will need to be reviewed periodically. Progress against the implementation of our co-production approach will also be important for improvements to equity. Our Shaping our Future Quality Excellence Programme is focussing on developing a Quality Management System for the UHB and on improving performance against specific quality challenges; Hospital Acquired Infections, Acute Deterioration, Lost to Follow-up and Medication Errors.	
Gaps in Controls	**Gaps in Assurances**
Lack of funding available for deliver planned care performance standards recurrently Both the clinical safety group and the clinical effectiveness groups are relatively new forums, and the Clinical Board quality and Safety governance needs to mature further to deliver a quality management system. Staff retention and recruitment vulnerabilities are impacting on case ascertainment for national audits. Many local improvements aligned to patient safety incidents are within the gift of the clinical boards to facilitate, however there are complex health board wide or national improvements for example delivery of scan for safety, implementation of a medical device register, whole system approach to observation and escalation that are dependent on resource Poor data collection on protected characteristics across the organisation.	• Approach to Quality Statements • Quality Outcome Framework • Resource for widespread health board wide improvements • Data improvements that will improve data monitoring of protected characteristics at the local level e.g. National Data Repository, a Population Health Management System for Wales and use of the NHS App in Wales

Risk Post-Controls and Mitigation			
Impact: 5	Likelihood: 3	Net Risk: 15	

Strategic Risks – Quality

Actions			
What	**Lead**	**By**	**Update**
Deliver stroke improvement plan to address quality concerns in acute stroke pathway	PB	31/12/25	• Business case approved for stroke model, funding to be released from Q4 2024/25 • Delays in recruitment for agreed stroke post • Recruitment is now underway to the additional posts, but it will be some time before all posts are in place. There is continued focus on stroke performance and a real increase in regional working to deliver sustainable models moving forwards. • Stroke performance remains stable – new SSNAP measures to be reported to Board in August. • Go-live of phase of regional thrombectomy service in July
Develop 6 goals workstream four objectives to transform continuity of care, hospital flow and length of stay	PB	31/05/2025 Action complete	• UHB launch of Reducing Time In Hospital in November – completed • 6 goals programme reframed for 25/26 to include two workstreams, one focused on secondary care and one primary. Detailed plan developed and will be signed off in Q1 • Action complete
Develop and deliver improvement plan for cancer and long waiting patients, including a plan to reduce diagnostic waiting times.	PB	31/03/26	• Delivery against revised trajectories is monitored internally and by WG • Challenging position in select specialities including ophthalmology • End of year positions in Cancer and 104 weeks for 24/25 good in comparison to recent years but still too long and not in line with WG expectations. Revised plans in place to deliver reduction during 2025/26 • Cancer performance remains best in Wales – further work to do to reach 75% • Long waits significantly reduced, meeting agreed trajectories for each quarter.
Develop and deliver long term proposal for ITU capacity – Strategic Outline Case in production	PB	31/12/25	• The design development continues. However, discussions are ongoing with WG in relation to a combined ITU/Haematology and Hybrid theatres schemes. • Interim plan for releasing capacity on 3rd floor in progress through discretionary capital programme – Work to C1 to accommodate Cardiology from C3 has commenced and is due to complete October 2025, releasing capacity ahead of the ITU work
Deliver the Theatres Together Programme which includes important quality elements such as the WHO checklist and productivity improvements	PB	31/03/2026	• Theatres Together Programme is underway, and updates provided through Board. Initial focus on 6 immediate actions and cultural priorities • Work on further tranches now underway
Review, design and improve mental health services which are noted to carry risks to quality	PB/DF	31/03/2026	• External consultancy appointed to support with review of mental health services – work ongoing • Plans for neurodevelopment services undergoing significant scrutiny
Development of a Quality Outcomes Framework- To support a data informed approach to quality	JR/ RS	31.06.25	• Meetings underway with corporate teams to agree quality indicators • Work to extrapolate data relating to patient safety incidents commenced

Strategic Risks – Quality

			• Plan to develop a first draft by Q1 with digital support by June 2025 • Publication of a UHB mortality dashboard • Publication and analysis of clinical board and directorate mortality dashboards
Development of the Quality prospectus to populate the quality academy – Up skill staff across the clinical boards in patient safety review technique, improvement planning and clinical governance	JR	31.03.26	• PSLR training developed • Improvement plan training in development • Human factor prospectus planning • Development of a quality academy • Accredited audit training in place
Monitoring of the Equity, Equality, Experience and Patient Safety Action Plan and progress against actions by Clinical Boards	CB	Every six months	• Paper for Quality Committee on progress against the action plan. • Early discussions with Public health around equity measures as part of the quality outcome framework

Shaping Our Future Wellbeing

Strategic Risks – Health Equity

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Health Inequity	Shaping our Population Health and Place Based Partnerships	Executive Director of Public Health	Quality	29 July 2021

Risk

There is a risk that lack of investment in prevention, primary care and community services coupled with a deterioration in the wider determinants of health will adversely impact our statutory duty to improve the health and well-being of our local population and our strategic ambition to reverse the historic trend in widening inequality in life expectancy for men and women living in Cardiff and Vale.

Cause	Impact
• People in the most deprived areas die earlier on average and live more of their lives in poor health; this is well recognised and deeply entrenched, but it is preventable. • People living in poverty are getting sicker and accessing services later. For the most deprived groups, EU attendances are nearly twice as high and emergency admissions more than double that of the least deprived. • In 2021 the *undiagnosed* diabetes rate was double for those in the bottom Indexe of Multiple Deprivation (IMD) quintile compared to the top.This presents a challenge for the NHS in finding those with an unmet need for healthcare. • Greater illness and poorer access to care (the inverse care law) contribute to worse health outcomes. This impacts directly on the gap in life expectancy between the most and least deprived groups. • Our organisation has set the strategic intention to shift spending from reactive care in hospitals to more prevention and proactive care in the community setting – but secondary care has attracted a greater share of NHS spending, meaning that prevention, primary care and community services have received a smaller share. This must be addressed for the sustainability of the organisation. Locally we call this left shift, a 'shift upstream' towards prevention. • Spending on prevention, and in primary and community settings had a superior return on investment when compared with acute hospital services. • There is strong evidence that areas that invest more in prevention and community care see 15 per cent lower non-elective admission rates and 10 per cent lower ambulance conveyance rates together with lower average activity for elective admissions and EU attendances. • Changing both the distribution of resources and the operating model to deliver integrated, preventative care closer to home are the strategic priorities of the	• We can reduce premature mortality, reduce social disparities, and reduce the absolute time in ill health. This in turn reduces the burden on the Health Board and social care while enabling our population to be more productive in our working lives, so strengthening the local economy. This is the desired outcome for individuals, families and the public purse. • Risk factors interact and multiple aspects of disadvantage come together, increasing the disease burden and widening equity gaps. • The key population groups with multiple vulnerabilities include: - Some minority ethnic groups, especially some people in Black and Asian populations - People living in (or at risk of) deprivation and poverty - People in insecure/low income/informal/low-qualification employment, especially women. - People who are marginalised and socially excluded, such as people experiencing homelessness and other inclusion health groups • Areas with higher unemployment have greater incidence of suicide; and people living in the most deprived areas experience the largest increase in mental illness and self-harm. • Health inequalities are estimated to cost £3-4 billion annually in Wales through higher welfare payments, productivity losses, lost taxes, and additional illness. • Lower levels of immunisation in the population have significantly increased the risk of outbreaks of diseases like measles. These will impact disproportionately more on our most deprived communities, with direct risks to health and by further negatively impacting on wider determinants such as education or employment. • The total annual cost associated with inequality in hospital service utilisation to the NHS in Wales is estimated to be £322 million, equivalent to 8.7% of the total hospital service expenses, driven largely by higher service use among people

Strategic Risks – Health Equity

organisation as described in the strategy, because they are derived from the changing needs of the population.

- Health inequalities are well documented across the UK, with a recurrent pattern of worsening outcomes linked to factors such as deprivation and ethnicity; these inequalities are evident for many chronic and acute conditions.
- Health inequalities arise in three main ways:

- structural issues, e.g. income, employment, education and housing
- unhealthy behaviours due to the environment, social norms and income levels
- inequitable access to, or experience of, services, which can be a result of discrimination due to inaccessible services, public information or healthcare sites that may be relevant/pertinent to particular needs.

- Differential experience of the wider determinants of health across the life course mean that disadvantage experienced in childhood is often compounded and exacerbated through adult life, and often passes inter-generationally.
- The 'Inverse Care Law' has been recognised for over 50 years, with those experiencing disadvantage consistently experiencing more challenges in accessing health services. Inequity of access to healthcare continues to be evident in Cardiff and the Vale of Glamorgan.
- Deprivation correlates strongly with rates of vaccination in the population, the gap in immunisation between the most and least deprived has been widening in recent years.
- The UHB also has a role as a care provider, employer and regional Anchor Organisation to positively impact the wider determinants of health for employees, patients and residents and to advocate for improvements to the wider determinants of health with other statutory partners.
- Lack of capacity to deliver evidence-based interventions at scale to tackle health behaviours e.g. smoking, diet, physical activity, alcohol, that drive the huge disparities in health outcomes we see across Cardiff and Vale.
- Lack of capacity to undertake more substantial work on the wider determinants of health with partners.
- Lack of investment in prevention, primary and community services, e.g. health visitors (UK staff shortages) and public health consultants (Faculty recommends 1 for a population of 500,000).

living in the more deprived areas compared to those living in the least deprived (PowerPoint Presentation (nhs.wales)

- There is a moral and financial sustainability imperative to address health inequalities in our Health Board.

Strategic Risks – Health Equity

Uncontrolled Risk			
Impact: 4	Likelihood: 4	Gross Risk: 16	Target Risk: 12

Controls	Assurances
1. Statutory duty • The Health Board has a statutory duty: to improve the health and well-being of the local population. • The Socio-economic Duty places a legal responsibility on public bodies in Wales when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. • **2. Role as an Employer** • In our Equality, Inclusivity and Human Rights Policy, we have an active programme, which sets out the organisational commitment to promoting equality, diversity and human rights in relation to employment, and ensuring staff recruitment is conducted in an equal manner. • Our Strategic Equality Objectives and Plan 'Shaping our Inclusive Culture 2024-2028, has a number of key delivery objectives and is premised on the basis of embedding equality, diversity and human rights, and Welsh language, into UHB business processes. • All our Executives have taken up a leadership role as an Inclusion Ambassador covering different characteristics, including those specified in the Equality Act 2010. Staff have been signposted to resources to help them to cope with the cost-of-living crisis. **3. Our Strategy and Plans** • The refreshed UHB Strategy 'Shaping our Future Well-being' shines a light on the issue of equity at the strategic level. • The Cardiff and Vale long-term public health plan 2024 – 2035 sets out how the UHB intends to achieve its ambitions of increasing life expectancy, reducing inequity and shifting more focus to prevention. • 'Shaping our Inclusive Culture 2024-2028' is closely aligned with the UHB Shaping our Future Well-being. • Through our PSB and RPB plans we already prioritise areas of work to tackle inequalities and the refreshed needs assessments for both PSBs and RPB have further identified collective actions. • The future UHB organisational direction agreed at the recent rapid planning event supports the 'shift upstream' by committing to develop an Integrated Community Health System, underpinned by care pathways that begin with prevention; prevention is a 'brilliant basic'. • The establishment of a Strategic Diabetes Programme Board is a key element to reducing health inequalities and has an aim to identify those with undiagnosed diabetes in areas of deprivation across Cardiff and Vale. • The Health Board is implementing and periodically reviewing its strategy to tackle the lower and unequal uptake of vaccination in our most deprived communities.	Board papers Committee papers to Quality Committee e.g. updates on Equity, Equality, Experience and Patient Safety Framework. Committee papers to People and Culture and Quality and Safety Committees e.g. updates on Welsh Language Standards. Risk Registers Integrated Performance Report Papers to SLT

4. Public Health Priorities to reduce health inequalities • As a team we have agreed three immediate priorities that will influence health inequalities (and other work that we will need to bring forward when capacity allows): - preventing obesity (focus 0-5 years) - reducing smoking rates (dependent on a new business case) - increasing levels of vaccination (using an outreach model to reduce inequity in uptake).	
Gaps in Controls	**Gaps in Assurances**
	Monitoring data (e.g. on protected characteristics) Population Health Management System to reduce inequalities by identifying those at risk

Risk Post-Controls and Mitigation			
Impact: 4	Likelihood: 3	Net Risk: 12	

Actions			
What	**Lead**	**By**	**Update**
Embed a 'Socio-economic Duty' way of thinking into strategic / operational planning, *beyond* complying with our statutory duty, and to always consider the unintended consequences of our actions	Claire Beynon/ Rachel Gidman	2025/26	• We plan to strengthen the strategic response to the Socio-economic Duty, ensuring actions are systematically applied. • The EHIA process is being reviewed on an All Wales basis with the view of creating a Once for Wales approach. C&VUHB will contribute to the development and implementation. The Health Board are also exploring opportunities as to how the EHIA process can be better embedded into governance processes and to make the process more user-friendly. • Our UHB will continue to work collaboratively with our stakeholders to shape our services and culture. • The UHB has recruited an Equity & Inclusion Manager who will start in October 2025, improving organisational capacity to support Clinical and Service Boards, including with awareness and training on completing EHIAs.
Within the UHB and through our PSB and RPB partnerships, continue to develop and deliver a suite of focused preventative actions to tackle inequalities in health	Claire Beynon	March 2026	Work to tackle inequalities needs to take place over prolonged time periods. In 2025/26 we will continue to work with PSB and RPB partnerships to address the three priority areas where we know we can make a significant impact on reducing health inequalities: smoking, vaccination and obesity. The Amplifying Prevention Board, held jointly with Local Authority partners, provides governance oversight of this collective action and works to remove any blocks to collective action.

			• The Head of Equity and Inclusion is a member of the Public Sector Equality Network, improving the collaboration between public sector organisations in the area.
			• An ongoing, opportunistic programme of MMR vaccination catch ups will continue until the end of the school year. This programme is delivered in school and community environments, also using the vaccination van to support outreach efforts in communities with lower uptake. The wider community delivery model of vaccination is also continuing, with an enhanced focus on delivering vaccination closer to home.
			• A more targeted, intelligence driven approach is being discussed with Cardiff Council and appropriate data sharing agreements are under development. It is expected to take some time before the correct information governance will be in place to support this and a Task and Finish group meets fortnightly to maintain focus on this.
			• The same intelligence driven approach is being used for analysing inequities of childhood vaccination in primary care. This work will help us to support General Practices in targeting and following up children in areas or communities with lower uptake. The Public Health Team's Data Analyst is developing dashboards that can be used to support discussions with individual GP surgeries in an accessible and interactive way.
			• Operational ~~planning is ongoing~~ plans are in place for the delivery of the injectable gelatine-free flu vaccination in the school setting during 2025. Community engagement activities are gathering insight on awareness of the gelatine-free options, and behaviourally informed communications, including an updated consent form, are being developed.
			• Our Health Improvement Officer works across Cardiff Council and the UHB's Public Health Team as part of a collaboration to improve our understanding of and engagement with ethnic minority communities. The aim of their work is to build trust with these communities, supporting us to understand and break down barriers to good health and wellbeing. The Officer is employed in this role by Cardiff Council, funded, via the Public Health Team, by a Welsh Government grant.
			•
			• An 'Equity, Equality, Experience and Patient Safety' action plan was developed, covering 24 initial actions across the Clinical Boards that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. This was approved by Board in May 2024. Progress on the actions is reported to Quality Committee on a 6-monthly basis. The most recent update was provided on August 5, 2025. As the actions are being completed, a review will be undertaken to identify further actions and steps. Highlights from the most recent update include:
			  • Progress has been made on the new health inclusion model based on need - there is a nurse in place between 9am-5pm to provide EU / ward in-reach. There is also a GP in place providing primary care in-reach to inclusion groups.
			  • People and Culture continue working on a number of initiatives to promote the UHB as an employer, aiming to build a workforce that genuinely reflects the rich diversity of the communities it serves.
			• ~~The most recent update in is due to be presented in August 2025. Feedback on progress from teams is in the process of being collected for this update. Current highlights include that:~~

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			~~• a Task and Finish Group has been established with respect to the Health Board's antiracist action plan, with organisational agreement to focus on progression and representation. A thorough analysis of data is underway to identify recruitment and progression barriers for our ethnically diverse colleagues and the anti-racism eLearning module on ESR has launched.~~ ~~• Cardiff and Vale Health Inclusion Service (CAVHIS) is now providing in-reach services to the Emergency Unit at UHW, with a nurse in place between 9am and 5pm to provide ED / ward in-reach and there are also now GPs providing primary care in-reach to inclusion health groups.~~ ~~• The Health Board has partnered with Cardiff Metropolitan University to conduct a bespoke research project exploring the experiences and barriers faced by care-experienced individuals in relation to employment.~~ • Work continues to meet targets in the existing plan, especially in relation to data collection to support data availability, linkage and analysis. A new action includes creating and developing an equity indicator dashboard. ~~Additionally, work seeking to identify any additional new actions to add to the plan has begun.~~ The next update on this work will be presented to the QSE in a further 6 months ~~As above, a further update on this is in the process of being collated and is due to presented to QSE in August.~~ • There have been improvements made to the way that pregnant smokers are identified and contacted with stop smoking support. An 'opt out' process has been adopted (all pregnant smokers will be contacted by smoking cessation services unless they explicitly request for this not to happen). The UHB's Community Smoking Cessation Services aim to ensure that clinic provision aligns to areas with higher smoking prevalence to reduce barriers to service access. Further work is also planned to improve outreach e.g. with housing association tenants. To support work on smoking cessation, partner organisations have shared materials, resources and information. This includes information on the introduction of the ban on sale of disposable vapes, and a new online resource to help people reduce vaping, and therefore dependence on nicotine.
Improve the routine data collection in relation to equality and inequity across the UHB.	Claire Beynon	March 2026	In 2025/26 there is an ongoing need to improve the routine collection of protected characteristics in order to support the introduction of new indicators. This will need to be addressed by each Clinical Board. Patient feedback is essential to improving service quality. Since October 2022, the UHB has collected most routine feedback via electronic surveys, accessed by SMS link, QR code and URL. We currently survey up to 1000 patients who have attended an outpatient appointment or following discharge as an inpatient every day; this includes the Emergency Unit (200), Mental Health (200) and the routine survey which randomly selects from all other clinical areas (600). As part of ongoing development, the routine survey has been translated into the top ten most frequently used languages, including BSL, English and Welsh. All surveys also collect information on protected characteristics, although this is not compulsory.

			The next phase will involve rolling out useful training tools and guidance on the intranet to support staff in engaging more effectively with patients and service users, helping them gather meaningful feedback about their experiences. This will be complemented by monthly feedback-in-focus sessions held across sites. A range of methods is used to gather feedback with the aim of ensuring all patients have the opportunity to contribute, including: • Website hosted surveys • Kiosk surveys • Tablet surveys • Postal surveys and paper-based feedback forms • Telephone surveys • SMS surveys • Focus groups • Patient stories • Bespoke • QR coded Bedside surveys The All-Wales Peoples Experience Framework was launched in April 2025. The new PES survey was implemented in May 2025 at the Health Board.

Strategic Risks – People

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
People	Shaping our People and Culture	Rachel Gidman	People and Culture	30 Sep 24

Risk

If we do not have the right people, the right culture and a healthy, effective workforce then we will not be able to provide the services to the population that we are required to and on which people depend.

Cause	Impact
1. Attract Recruit Retain • The increased demand across the NHS and Social Care has left a shortage in some professions and the sustained pressures have impacted negatively on wellbeing and retention. • National shortages in some professions have made it difficult to attract people with the right skills/experience and in the numbers required. • Attraction, recruitment and retention is also being affected by the negative image that is portrayed that NHS staff do not receive the right remuneration for the work that they do. The Industrial Action over the last couple of years has not helped the national reputation of the NHS as an employer. • People now think differently about work and what is important to them.	• Higher levels of sickness absence • Lack of management capacity to support staff appropriately; - Higher levels of turnover; - Low morale and poor staff engagement; - Increased reliance on temporary workforce e.g. bank, agency, locums, etc; - Reduced capacity to undertake appraisals, identify development needs, and focus on talent management and succession planning. - Lack of capacity to upskill and develop our current workforce. - Reduction in uptake of student training places and higher attrition rates, resulting in a reduction of graduates. • Potential negative impact on quality of care & safety. Inability to expand services as required due to lack of staff with the relevant experience, skills, etc.
2. Culture • There is a belief within the organisation that the current climate is high in bureaucracy and low in trust. • Staff reluctant to engage with the case for change as they are overwhelmed with system pressures, change and ongoing demands. • Staff are not feeling involved in, or understanding the part their role plays for the case for cultural change due to lack of communication filtering through all levels of the UHB. • Additional complexities as colleagues continuously respond to the challenges of the pandemic, making involvement in, and response to change complex and challenging.	• Staff morale may decrease • Increase in absenteeism and/or presenteeism • Difficulty in retaining and recruiting staff • Potential decrease in staff engagement • Increase in formal employee relations cases / respect and resolution • Transformation of services may not happen due to staff reluctance to drive the change through improvement work. • Patient experience ultimately affected. • UHB credibility as an employee of choice may decrease • Staff experiencing fatigue and burnout making active and positive engagement in change challenging and buy-in difficult to achieve. • Existing inequalities exacerbated • Not realising the opportunities within workforce sustainability

Strategic Risks – People

3. Wellbeing • Lack of integration and understanding of importance of wellbeing amongst managers • Impact upon manager wellbeing of balancing staff and service needs • Conflict between demands of service delivery and staff wellbeing • Exposure to psychological impact of increasingly complex and challenging demands of care • Inability to deliver care to required standard due to short staffing (moral injury / moral distress) • Ongoing demands over an extended period of time • Cost of living • Financial climate	• Values and behaviours of the UHB will not be displayed due to high pressure environments, and potential for exacerbation of existing poor behaviours • Operating on reduced staff levels in clinical areas due to sickness absence and/or staff shortages • Mental health and wellbeing of staff will decrease, existing MH conditions exacerbated • Clinical errors will increase • Staff morale and productivity will decrease • Job satisfaction and happiness levels will decrease • Increase in sickness levels • Patient experience will decrease • Increased referrals to Occupational Health and Employee Wellbeing Services (EWS) • Increased referrals for higher level psychological support • UHB credibility as an employer of choice may decrease • Potential exacerbation of existing health conditions Impact on retention (negative) and attraction of staff into healthcare

Uncontrolled Risk			
Impact: 5	Likelihood: 4	Gross Risk: 20	Target Risk: 10

Strategic Risks – People

Controls	Assurances
• The People and Culture Committee provide more scrutiny and assurance to Board. • People and Culture Plan in place with a robust governance structure monitoring delivery against the agreed priorities. • Monthly Executive Review meetings with Clinical Boards • Strategic oversight meetings, e.g. NPG, MWAG and introduction of MPG (Medical Performance group) • Cardiff and Vale UHB refreshed strategy: Shaping Our Future Wellbeing • Talent management and succession planning framework • Values based recruitment / appraisal • Strategic Equality Plan • Anti-Racist Action Plan • Workplace Race Equality Standards (2024) • Welsh Language Standards • Patient experience score cards • Raising concerns procedure/Speaking up Safely. • Widening Access Framework • New Starter Surveys and Exit Questionnaires/interviews • Nursing Staff in Post Forecasting to identify potential risks in advance Adoption of consistent, evidence-based approach to Culture and Leadership via the NHSE Culture and Leadership Programme Staff survey	• Robust monitoring of People and Culture Plan KPI's at the People and Culture Committee and Board. (1) • Quarterly IMTP/Annual Plan updates to WG. • WG JET and IQPD • Effective partnership working with Trade Union colleagues (WPG, LNC, LPF). • Internal Audit on Staff Wellbeing, Culture and Values (Sept 2022) report (3); • Engagement of staff side through the Local partnership Forum (LPF) (1) Matrix of measurement now in place which will be presented in the form of a highlight report to Committee (1) • Internal monitoring and KPIs within the OH&EHWS (1) • Wellbeing champions normalising wellbeing discussions (1) • VBA focussing on individual wellbeing and development (1) • Successful retention of the gold (and platinum) Corporate Health Standard awards via the 'Enhanced Status Checks' in March 2023 • Substantive funding identified to maintain on a permanent basis the enhanced EWS service from April 2023 • Development of a new and permanent OD Manager - Wellbeing and Engagement role • Taking Care of Carers Audit and Action Plan to become part of Business as usual (3) • Internal audit on Staff Wellbeing, Culture and Values (September 2022) Report and implementation of Management Actions (3) • Trade unions insight and feedback from employees (2) • Working with HEIW as part of the Financial Wellbeing (FWB) task and finish group to develop a FWB strategy for NHS staff in Wales (2)
Gaps in Controls	**Gaps in Assurances**
Agreed Retention Plan for all staff. Retention & OD Lead for the UHB • Workforce supply affected by National Shortages. No leadership / management principles as a UHB (currently align with HEIW compassionate leadership principles) • No organisational cultural dashboard	Capacity to respond to requests for cultural and transformation work Effective measures of culture / engagement • Organisational acceptance and approval of wellbeing as an integral part of staff's working life balanced against demand and flow • Awareness and access of employee wellbeing services, particularly for staff without email / internet access

• Staff shortages / industrial action leading to movement of staff and high demand for cover • Transparent and timely Communication especially to staff who do not have digital access • Continued increase in manager referrals to Occupational Health • EWS seeing an increase in staff presenting with more complex issues, including a rise in referrals needing a wellbeing check due to the presentation of high risk in the referral • No Colleague Health and Wellbeing Framework	• Clarity of signposting and support for managers and workforce

Risk Post-Controls and Mitigation		
Impact: 4	Likelihood: 4	Net Risk: 16

Actions			
What	**Lead**	**By**	**Update**
Agreed Retention Framework to support retention for all staff groups, aligned to HEIW Principles and HEIW Nurse Retention Plan. Attract, Recruit and Retain is one of the key three themes of the People and Culture Action Plan which is monitored on a monthly basis to ensure good progress.	Claire Whiles	Oct 2025	• The All Wales self-assessment was due on the 31 March 24. The organisation completed and submitted. • Draft OD, Wellbeing and Culture Framework and Toolkit produced and under review. To be ready for publication and engagement October 2025.
To develop management and leadership development where compassionate and inclusive leadership principles will be at the core of all the programmes. Saunders.Nathan 21/09/2025 15:54:19	Claire Whiles	Oct 2025	• Management programmes continue to be delivered and evaluated using the Kirkpatrick model (introduced Q1 2024) • Compassionate Leadership masterclasses developed via 'train the trainer' session with Professor Michael West. Delivered regularly. Ongoing review and evaluation in place. • Leadership, Management and Skills programme for Band 8C and 8B (Optimising Ops) agreed and will commence ~~August~~September 2025 for 8C managers. Exploring regional delivery with ABUHB and CTMUHB to enhance resilience, content and regional working. • Elev8 Programme to be launched September 2025 to support Advancing Clinical Leadership. A multi-disciplinary programme to support Band 7

			clinical leaders in order to successfully lead compassionate, accountable and improvement focused teams. ~~To launch September 2025~~. • • Successful recruitment to Head of Leadership and Management position, individual will commence in role October 2025. Work continuing until that time, overseen by Head of OD and Culture. We continue to work closely with HEIW to align leadership principles to 4-nations work on leadership and management competencies. Focus on management development focused on brilliant basics - managing attendance and wellbeing, accountability and ownership, compassionate leadership. • All programmes underpinned by compassionate and inclusive leadership principles and aligned to the all-Wales leadership competencies and principles. • Connected to Isle of Wight and Portsmouth NHS Trusts to identify key learning around the Culture and Leadership Programme. Two meetings held to date, ~~currently reviewing documents~~ documents reviewed and key learnings considered. ~~shared to benefit from learning and outcomes achieved.~~ • • ~~Paper on the introduction of~~ 'Cultural Safety Zones' concept being taken to 'Spread and Scale Academy' in October 2025, 6 key stakeholders presenting work. ~~in draft for discussion with teams including quality and safety, audit. Exp[loring~~ This links to Culture and Leadership Programme, Ward accreditation, Service Reviews and Compassionate Leadership Pledge. Supported by TU partners. • Thorough TNA will be required to support effective leadership and management development. Looking at Management Passport for all managers to ensure underpinning knowledge. • Self, Team and Team of Teams pilot leadership programme delivered to Peri-Natal Colleagues April 2025. Evaluation with HEIW to~~i~~ review next steps.
Equality, Diversity and Inclusion	Claire Whiles	Oct~~September~~ 2025	• Continue to monitor the delivery of the Strategic Equality Objectives and Plan through annual reporting.
Welsh Language Standards being implemented.	Claire Whiles	~~Sep~~Oct 2025	• Continue to improve capture of Welsh language skills data through 'making every contact count' approach (i.e. Staff Survey roadshows).

Strategic Risks – People

			○ ~~Increase of 2.33% (currently 55.7%) registered Welsh language skills since March 2025.~~Current registration is 53.7%, an increase of 5.08% from August 2024 to August 2025. • Resolve the three Standard Enforcement Investigations currently open with the Welsh Language Commissioner. • Concern raised by Welsh Language Commissioner regarding signage in Neonatal Clinic in UHW has been resolved. • Continue to communicate and deliver Welsh language learning opportunities with Dysgu Cymraeg Caerdydd.
Inclusion - Nine protected Characteristics	Claire Whiles	~~Sep~~Oct 2025	• LGBTQ+ Action Plan development on pause due to capacity, to be revisited and re-energised upon commencement of E&I Manager in October~~September~~ 2025. • ~~I~~WRES report received by UHB, currently being reviewed and meeting with Welsh Government planned for 15~~August/~~September 2025 to discuss findings and proposed actions. Papers will also be taken to SLT and P&C Committee • Re-assessment taking place to retain Disability Confident Leader status.
Commissioning model / whole team approach introduced in People and Culture to ensure managers / teams can request support / advice / guidance and training which is delivered / supported by the most appropriate team / individuals and/or external partners. Includes representation from ECOD, People Services, Wellbeing Services, Equity and Inclusion.	Claire Whiles	September 2025	• People and Culture Team working in collaboration with HEIW and Professor Michael West to review and improve culture and leadership programme implementation, monitoring and evaluation. Measures to be established and lessons learnt internally and via NHS England to be under-taken. Meeting with Portsmouth and Isle of Wight NHS Trusts has taken place and shared documents and reports in review. • P&C MDT established and reviewing organisational requirements in interim. Priority setting meeting scheduled for August 2025. • Priority cultural work currently identified and allocated by Chief Operating Officer, EDofP&C and appropriate Executive Directors. Elements of work paused due to Service Review requirements, but action plans now shared and OD/P&C input identified and in planning stage. • Progreess on OD, Wellbeing and Culture Framework detailed above.
The People and Culture Team will identify insights from workforce data, including themes emerging from EWS, OH, People Svcs, Culture work and Staff Survey, to shape strategic and operational response to themes / emerging trends. This will also be informed by working in collaboration with Clinical Boards.	Claire Whiles	August-Oct 2025	• Developments required to P&C Dashboard to ensure include all relevant measures, e.g. OH and EWS KPIs. Working with HEIW to improve dashboard reporting. • OH KPIs regularly reported to WG and KPIs adjusted to align with Welsh Government guidelines (i.e. calendar days). Collaboration review scheduled for ~~August~~September 2025.

			• Internal audit of OH Services moved to Quarter 3, 2025 at request of Audit Team. • NHS Wales Staff Survey 2024 reporting at CB Exec Reviews and SLT. Engagement in 2025 NHS Wales Survey ~~to commence~~commenced August 2025 in readiness for launch in Oct 2025. Thorough engagement and communication plan supported by P&C Team and TU Partners. • OPAS database implementation underway in EWS to support effective reporting and user experience. Licences procured, in initial stage of handover.. •
1. Enhance communication methods across UHB - Social media platform - Regularity and accessibility of information and resources Improve website navigation and resources	Claire Whiles	Oct 2025	• Draft OD, Wellbeing and Culture Framework and Toolkit produced and under review. To be ready for publication and engagement October 2025.People Health and Wellbeing Services currently reviewing sharepoint pages for staff following move to Woodland House and staffing changes to ensure most up-to-date information available. Working closely with Public Health Team to ensure consistent engagement around health priorities, including vaccination.
2. Training and education of management - Integrate wellbeing into all parts of the employment cycle (recruitment, induction, training and ongoing career) Enhance training and education courses and support for new and existing managers	Claire Whiles	Oct 2025	• Colleague and Manager wellbeing included in all management and leadership programmes, induction. • ~~Will be~~ This is included within leadership and management principles development and leadership programme development as above. • Management training under review and refresh to focus on wellbeing and keeping people well at work. Managing Attendance at Work training reviewed and re-launched April 2025, supported by digital learning. Positive responses to training to date – e-learning element due for launch ~~July~~September 2025 following review. • Successful recruitment into Head of Leadership and Management post, role will enable distinct focus on development of existing and future leaders and managers.To commence Oct 2025. • Elev8 Programme to be launched to support Advancing Clinical Leadership in September 2025. A multi-disciplinary programme to support Band 7 clinical leaders in order to successfully lead compassionate, accountable and improvement focused teams. ~~To launch September 2025~~. •
Wellbeing interventions and resources to be evidence based, targeted, reviewed and evaluated.	Claire Whiles	~~September~~ November2025	• EWS continue to offer evidence based interventions and review and enhance offer, e.g. Spring; EMDR

Strategic Risks – People

			• Operating model review and 3 year plan to be developed to support delivery of the People and Culture Plan and organisational priorities, including trauma informed support and pathways. • Service currently impacted by staffing shortages (sickness absence), this is affecting reporting and administration. Team working together to resolve. • Improvement required across UHB to ensure consistency of offer, e.g. Trauma response / psychologist intervention / evidence based practice. Paper developed and to be presented to Management Executives in first instance. • Staff Fast Track Trauma Pathway under review due to increase in waiting times, proposal within paper as outlined in bullet point above.~~.~~ • Communications and education around Trauma Pathway to be enhanced following feedback and collaboration with the Trauma Pathway Multi-Disciplinary Team. • Trauma Risk Management (TRiM) proposal presented at Senior Leadership Board for feedback, business case in development for presentation as part of paper detailed above. • Review of EWS and OH service based upon direction of 'Brilliant Basics' to align to organisational priorities and support reduction in waiting times. To follow collaboration review (~~September~~October 2025)

Strategic Risks – Digital

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Digital	Shaping our Future Digital Services	Director Digital and Health Intelligence (D&HI)	Digital and Infrastructure	4 October 2022

Risk

CAVUHB has legacy and deficit in human resources, skills and capability, infrastructure, applications and informatics. The digital estate has grown but the supporting resource has not. Without resourcing our Digital and Data transformation plans and Roadmap we risk the achievement of our SOFW objectives

Cause	Impact
CAVUHB IT and digital services are known to be historically underfunded resulting in a legacy and deficit in infrastructure, applications and informatics capability that has built up over at least a decade (e.g. our core applications for UEC, inpatients and outpatients were developed in-house-c20 years ago). There are plans to rectify these issues however they are unachievable with the current resource (people, finance) allocation We have some capability in human resources but insufficient capacity or funding to execute the digital and data transformation plans and road map. Existing resources are fully consumed with tactical short-term on the day-to-day urgency of UHB operational needs Recruitment of suitably skilled D&HI staff is a national challenge as well as affecting CAV. This often requires the use of interim agency support in key areas, especially whilst we continue with legacy solutions as we are tied to old technologies. This of itself diminishes further our existing capacity as resources need to be familiarised with the technical environment and then supervised. Historically CAV has looked to provide much of its core IT and digital services inhouse. This is not always necessarily the optimum route however 'legacy lock' and the resource to support forward plans keeps us where we are. Meanwhile with new initiatives the technical estate grows and the gap between what we have and what we can support/refresh widens.	Colleagues need mobile, scalable, agile solutions that enable data collection and sharing. This is unachievable whilst we are locked into legacy. Legacy Lock makes improving our cyber posture more challenging (e.g. securing our data) The impact of not managing this risk is that the improvements in safety, quality, outcomes, productivity and financial efficiency that staff and patients expect from D&HI cannot be fully realised, therefore putting at risk the deliverability of the SOFW Strategy.

Strategic Risks – Digital

Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 20

Controls	Assurances
• Digital strategy approved by Board in 20/21 with roadmap for 21/22/23 - these will be refreshed by April 2025 • Roadmap to support the strategy shared with DHIC covering 2024/27 - these will be refreshed by April 2025 as part of the Digital Foundations PBC work • Digital components described in IMTP – focussed on in year national and clinical board priorities • £466K is being invested by CAVUHB in the development of a Digital Programme Business Case (PBC) to seek All Wales Major Capital Funding alongside a Business Justification case (BJC) for phase 1 of the 5 annual phases. This work will complete in 12 months. • The work will deliver a clear trajectory, costs and plans on how CAV will achieve its target of HIMSS[1] Level 3 in pursuit of its intention towards a modular EPR, consistent with national and regional initiatives. The capabilities the PBC and business justification cases will describe are harmonious with and would segue into any nationally agreed and funded EHR solutions through interoperability and concordance with the "All Wales" Infrastructure review. o Work is expected to begin Oct/Nov 2024. o This follows positive discussions with WG IIB and NHS CDIO,	• All Controls are shared and discussed with the DHI Committee which meets quarterly. • The Digital Foundations case was scrutinised and approved by the Investment Group and Strategic Leadership Board. • The Director D&HI shared the intentions of the Digital Foundations investment case and updated WG's chief digital officer, whilst the DoF has discussed with IIB Lead. Both are supportive of approach and our intentions • Recruitment and procurement is underway for the resource to produce the PBC and BJCs • Risk register articulates the risks of not being able to deliver digital solutions to support delivery of healthcare (1) • Internal audit report highlights the risk in delivering digital strategy citing the investment challenges that will prevent full implementation.

Gaps in Controls	Gaps in Assurances
Current annual discretionary funding is insufficient to cover the maintenance upkeep of the core infrastructure and there is no headroom for innovation	Unable to currently provide assurance that the finance will be provided

Risk Post-Controls and Mitigation		
Impact: 5	Likelihood: 4	Net Risk: 20

Strategic Risks – Digital

Actions			
What	**Lead**	**By**	**Update**
Internal investment case to support the Digital Foundations case approved	Director of DHI	Sept 25	Programme Business Case completed and shared with WG setting out detailed roadmap plans and the associated costs, funded accessed by annual Business Justification Cases to WG's Major capital budget. Statement of works produced against which a suitable external partner will be sought Digital Foundations Programme Business Case and supporting Business Justification Cases for Year 1 (of the 5 year case) complete. PBC being taken through the internal governance process comprising Capital Management Group, Value & Benefits Realisation Group, Senior Leadership Team, F&P and D&I committees before presenting to the November Board meeting and thereafter submission to Welsh Government for their consideration/approval.
Development of the Digital Programme Business case to support the digital foundations ambitions is underway.	Director of DHI	Dec 25	External partner identified and service procured which has enabled the works to commence on the Programme Business Case. Co-production approach with all Clinical Boards and corporate services involved via workshops taking place during May and June 2025. July 25: Draft plans and outputs from workshops shared with Clinical Boards for comment prior to feeding into the Programme Business Case in Sept/October 25. Digital Foundations work to support the development of the Programme Business Case and supporting Year 1 Business Justification Cases complete. Workshops held with input from all Clinical Boards and services to ensure full co-production and alignment with the organisation's strategic objectives.

Strategic Risks – Infrastructure

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Infrastructure	Shaping our Future Infrastructure	Exec Dir Finance	Digital and Infrastructure	12 November 2018

Risk

There is a risk that the condition and suitability of the UHB estate, IT infrastructure and Medical Equipment impacts on the delivery of safe, effective and prudent health care for the patients of Cardiff and Vale UHB.
The condition of facilities within our main hospitals and some community facilities are impacting on our ability to continue to provide the full range of services and provide the would like to commission from us. This is as a result of insufficient funding and resource to bring the estate up to the required condition in a timely way.

Cause	Impact
• Significant proportion of the estate is over-crowded, not suitable for the function it performs, or falls below condition B (assessed regularly on an all-Wales basis by NHS Shared Services Partnership). • Investment in replacing facilities and proactively maintaining the estate has not kept up the requirements, with compliance and urgent service pressures being prioritised. • Lack of investment in IT also means that opportunities to provide services in new and efficient ways are not always possible and core infrastructure upgrading is behind schedule. • Insufficient resource to provide a timely replacement programme, or meet needs for small equipment replacement • Lack of timely decisions regarding the development of strategic business cases required to address the significant estates challenges we face.	• The health board is not able to always provide services in an optimal way, leading to increased inefficiencies and costs. • Service provision is regularly interrupted by estates issues and failures. • Patient safety and experience is sometimes adversely impacted. • • Medical equipment replaced in a risk priority order where possible, insufficient resource for new equipment or timely replacement • Staff facilities needed to support good staff wellbeing are inadequate in many areas.

Uncontrolled Risk

Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 15

Strategic Risks – Infrastructure

Controls	Assurances
• Estates strategic plan in place which sets out how over the next ten years, plans will be implemented to secure estate, which is fit for purpose, efficient and is 'future-proofed' as much as possible, recognising that advances in medical treatments and therapies are accelerating. This is being updated. • Statutory compliance estates programme in place – including legionella proactive actions, and time safety management actions. • The strategic plan sets out the key actions required in the short, medium and long term to ensure provision of appropriate estates infrastructure. • The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP/annual plan, with regular oversight of the programme of discretionary and major capital programmes. The 2025/26 Capital Plan will be submitted for Board with the IMTP • Medical Equipment prioritisation is managed through the Medical Equipment Group and there is a process in place for rapid decision making if there is a urgent need to replace a piece of equipment. This part of the Capital Management Group agenda. • Business Case performance monitored through Capital Management Group every month and Finance & Performance Committee at each meeting, every month. • Welsh Government has asked all NHS organisations to provide a prioritised capital programme using a weighting framework developed by the Infrastructure Investment Board. The submission date is 31st March 2024. The Health Board's submission has been scrutinised and approved through the internal governance mechanisms and is coming to the Board on 28th March for oversight. • The outcome of the WG prioritisation process was confirmed and the schemes which they have indicated support include The Vascular/MTC theatres, Haematology including BMT and ITU refurbishment. Following discussions with WG colleagues the UHB are developing options for the delivery of these projects which could include an integrated new build facility. • Discussion with Welsh Government regarding the Shaping Our Future Acute Hospital Programme continues, albeit that there has been somewhat of a hiatus over the last 9 months. The initial focus will be on the delivery of a master planning exercise to determine the most appropriate direction of travel to deliver new facilities to support the delivery of clinical services into the future. The tender documentation and specification is being finalised with the intention to procure a supplier by the end of 2025.	• The estates and capital team is in constant dialogue with WG and continues to present business cases to secure the necessary capital to address the major short/medium term service estates issues. This has proven successful in the closing months of the financial year A significant amount of end of year funding has been secured, as in previous years, and this has enabled capital investment in critical digital infrastructure in particular. • The statutory compliance areas are monitored every month in the Capital Management Group to ensure that the key areas of risk are prioritised and reporting of estates risks to the Health and Safety Committee has been strengthened(1) • The Executive Director of Strategic Planning and the Director of Capital, Facilities and Estates meet regularly with the Welsh Government Capital Team to review the capital programme and discuss the service risks (3). • Regular reporting on capital programme and risks to Capital Management, Management Executive and Finance & Performance Committee (1) (2) •) • Health Care Standard completed annually (3) • Medical equipment risk registers developed and managed by Clinical Boards, reviewed at UHB medical equipment group (1) (2) • Finance and Performance Committee continue to oversee the delivery of the Capital Programme (1) • A way forward in relation to the Shaping Our Future Hospitals Strategic Outline Case is being progressed by the Health Board(3) Risk Register reporting to D&I Committee

Strategic Risks – Infrastructure

Gaps in Controls	Gaps in Assurances
• The current annual discretionary capital funding is not enough to cover all of the priorities identified through the risk assessment and IMTP process for the estate and medical equipment replacement services which requires the need to prioritise investment and resource allocation based on assessed level of risk and alignment with strategy and IMTP priorities. • In year requirements further impact and require the annual capital programme to be re-prioritised regularly. • Traceability of Medical Equipment • The Welsh Government current capital position is very compromised due to size of budget compared with estimated need which will impact significantly on the Capital Programme of the UHB. Not all business cases in the Welsh Government capital plan will be deliverable and the UHB needs to be mindful of the potential reputational risk of delays between OBC and FBC approvals with supply chain partners.	• The regular statutory compliance surveys identify remedial works that are required urgently, for which there is no discretionary capital funding identified, requiring the annual plan to be re-prioritised, or the contingency fund to be used. • Medical equipment is also subject to regulatory requirements, and therefore requires re-prioritisation during the year. • Despite the substantial end of year capital, the recurrent position remains unchanged. • Full condition surveys of all buildings have not been carried out so not possible to fully understand the condition of the estate.

Risk Post-Controls and Mitigation			
Impact: 5	Likelihood: 4	Net Risk: 20	

Actions			
What	**Lead**	**By**	**Update**
Risks to infrastructure which have been identified are developed into robust plans for mitigation. These are prioritised through our annual planning work and identified	Geoff Walsh	Annual plan	The discretionary capital is prioritised to meet our annual plan. Prioritised plan is signed off by CMG and SLB and Board. Significant risks or financial requirements are raised regularly with Welsh Government to support when necessary. WG Targeted Estates Funding received which will address some of the highest risks identified on the CEF Risk Register. Schemes which received approval have been reported to CMG and SLB
Where estate is no longer required for the provision of care or services a programme of decommission, disposal or demolition is undertaken to minimise the estate and infrastructure which the Health Board needs to maintain.	Geoff Walsh	Annual plan	Decommission priorities – Denbeigh and Carmarthen house have been vacated, and planning permission is being sought for their demolition, along with Brecknock House and the recently vacated Sports and Social club CEF are working with the Specialist Clinical Board on options to re-locate ALAS and deliver a single site option for the service Disposal plans – Rookwood the UHB have identified a preferred bidder following a comprehensive disposal exercise and are working with them to develop the proposal, including Heads of Terms etc.

Strategic Risks – Infrastructure

A condition survey will be undertaken to understand in detail the status of the Health Board estate with a view to inform a future investment priorities and estate needs.	Geoff Walsh	December 2025	The scope and plan for the condition survey have been shared with and supported by Welsh Government. The site survey work has progressed well and, the delivery of the final report is due by the end of 2025.
~~An acute infrastructure group is overseeing the short – medium term priorities and a programme of work is progressing Shaping Our Future in the Community Programme Board oversees the capital infrastructure requirements for community based care and a prioritised business case pipeline is in place. This work dovetails with the RPB 10 year capital plan and the Cardiff PSB Asset Management Group.~~	~~Geoff Walsh~~	~~Ongoing~~	~~Following a review of the governance arrangements for the management and oversight of capital projects etc, it has been agreed to step down the AIB and introduce Project Boards for major schemes with less complex and lower value scheme reporting directly to CMG~~

Strategic Risks – Sustainability

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Sustainability	Shaping our Future Generations	Exec Dir Finance	Finance and Performance	1 April 2022

Risk

If the organisation cannot produce a balanced 3-year plan or a balanced IMTP in any year it will breach its statutory financial duty and will be limited in the ability to deliver on the strategy and so the services to the population that the organisation serves.
If the organisation cannot protect the environment and take the steps required of it regarding waste, carbon footprint and other deliverables, it will not be an efficient service and will jeopardise the health of future generations.

Cause	Impact
Finance The UHB has to manage its operational budget. In the absence of a 3 year approved IMTP the UHB works to One Year Operational Plans from year to year. These still require significant savings achievements within each financial year irrespective of a deficit year end projection. Decarbonisation The UHB has to achieve 16% and 34% emission savings from a 2018/19 baseline by 2025 and 2030, respectively, aligned with Welsh government targets. Additionally, the "Shaping Our Future Wellbeing" strategy targets a 40% reduction in directly controlled emissions by 2027. ~~In the last calculated emission report, total emissions increased by 7% to 217,000 tonnes, while emissions under our control reduced by 7%. CAVUHB is not on track to achieve the 16% reduction target set by the Welsh government for 2025.~~ In 2024-25 the UHB's emission has increased by 44% to c260,000 Tons of Co2 compared to 2023-24 emission of c180,000. **The UHB has already missed Welsh Government target of reducing its emission by 16% by 2025.** ~~To meet the aims outlined by UHB in the strategy, we must reduce emissions under our control by 10% annually starting since 2023/24.~~ Saunders,Nathan 24/09/2025 15:54:19	Breach of statutory duties, escalation. Unable to deliver a balanced year-end financial position. Reputational loss. Inefficient or reduced service delivery Decarbonisation and Climate Impact Risks: Strategic Risks: CAV UHB is not in line of sight of achieving neither Welsh Government targets nor targets set by Shaping Our Future Wellbeing Strategy as our emissions are increasing, in 2024-25 the UHB's emission has increased by 44% to c260,000 Tons of Co2 compared to 2023-24 emission of c180,000. **The UHB has already missed Welsh Government target of reducing its emission by 16% by 2025.** Operational Risks: Initial findings from our ongoing heatwave survey reveal that **80% of staff reported high levels of discomfort, with 32% experiencing health effects during recent heatwaves**. Preliminary analysis of climate data also indicates a projected increase in the frequency and intensity of heatwaves. These figures underscore the urgent need to protect our workforce and adapt our care environments to ensure resilience in the face of escalating climate risks. Financial Risks: The impact of climate change on the UHB is multidimensional and cascading. Initial findings from the heatwave survey indicate a **~30% of clinicians have observed an increase in**

Strategic Risks – Sustainability

Climate Impacts:

The world has breached the 1.5°C pathway set by the Paris Agreement in 2024. Growing evidence shows that the magnitude of climate impacts is increasing day by day, and Cardiff is projected to be one of the most affected cities in the UK. The Welsh government has made it mandatory for UHB to submit an annual qualitative report on climate adaptation.

Currently, UHB has not undertaken a comprehensive assessment of current and future climate risks. This renders UHB vulnerable to unidentified climate risks that have a direct impact on healthcare delivery and its financial situation.

Resource Risks:

CAV UHB has just ~~one~~ limited resource ~~dedicated staff~~ for Sustainability and Climate response, this will impact on~~has been a big strain on~~ embedding sustainability and building climate response.

Saunders.Nathan 21/09/2025 15:54:19

patient footfall during and immediately after heatwave periods. Additionally, there were reports of extended patient length of stay, attributed to poor rehabilitation outcomes and delayed recovery. These are just some of the emerging consequences. With the projected increase in the frequency and intensity of climate events, such impacts are expected to intensify, ultimately leading to a greater financial strain on the Health Board.

Legal Risks:
Across the UK, public sector organisations and local authorities are increasingly facing legal action for failing to take sufficient steps to meet their emission reduction targets and to adapt to the changing climate. CAV UHB's current trajectory of not meeting its emission reduction targets and showing slow progress on climate adaptation could expose the organisation to climate litigation risks.

~~Decarbonisation:~~

- ~~UHB will not achieve its targets for decarbonisation in its current pathway and this will render UHB answerable to Welsh Government.~~
- ~~Reputational loss due to not achieving Shaping Our Future Wellbeing" strategy's target of 40% reduction in directly controlled emissions by 2027.~~
- ~~If the yearly emission reduction pathway is not designed and followed it will lead to risk of spending more at a later time to meet the set-out targets.~~

~~Climate Impacts:~~

- ~~Initial sift of evidence and analysis shows that, given Cardiff's growing older population along with increased climate impact, vulnerability in the region is set to rise. This translates into more hospital admissions, increased patient flow, and ultimately, increased healthcare delivery costs for UHB.~~
- ~~Operationally, given the aging assets and assets exposed to weather events, there will be increased physical impacts on UHB's assets.~~

	• ~~A comprehensive risk assessment has not been conducted, and a climate adaptation plan to mitigate the risks is not in place, UHB's understanding of its climate risks is limited and capacity to adapt are limited.~~

Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 10

Controls	Assurances
Additional expenditure is being authorised within the governance structure and the UHB Scheme of Delegation. Financial Plan submitted to Welsh Government in March 2024 explaining inability to deliver financial balance over the three-year period 2024-2027. The Savings programme is managed through weekly Senior Leadership Team and a series of Financial summit events chaired by CEO aligned to the National Value and Sustainability Board and the annual planning framework enabling actions Decarbonisation A decarbonisation action plan is in place to deliver decarbonisation actions aligned with the NHS Wales Decarbonisation Strategic Delivery Plan 2021-2030. SusQI has been implemented to embed sustainability in Q&I projects. The Welsh Government has mandated yearly reporting, such as Decarbonisation Co-Ordination Reporting and Emission Reporting, along with all other health boards in Wales. Climate Impacts The Welsh Government has made it mandatory to report qualitatively on progress regarding climate adaptation. A task and finish group has been established to identify pathways for climate risk assessment and climate adaptation pathways.	The financial position is reviewed by the Finance & Performance Committee which meets monthly and reports into the Board (1) Financial performance is a standing agenda item monthly on Senior Leadership Team with escalation to Management Executives Meeting (1) Financial performance is monitored by the Management Executive (1). Assurance from internal audit annual review of core financial controls including budgeting and planning. Senior Leadership Team is now weekly to ensure savings delivery, chaired by the Chief Executive. Additional measures implemented IY as set out in actions below Decarbonisation plan is developed annually and overseen by Finance and performance committee

Strategic Risks – Sustainability

Initial conversations are being held with the MET Office to collaborate and conduct a comprehensive Multi-Risk Assessment, starting with the impacts of heatwaves on our operations.	
Gaps in Controls	**Gaps in Assurances**
Decarbonisation The current financial landscape doesn't allow UHB to meaningfully develop plans to hit NHS Wales targets or the targets set out by the strategy. Given the complexity of decarbonisation actions across various departments of the UHB, there is a lack of continuous, robust monitoring. This would require the reestablishment of a digital climate change program dashboard, setting of qualitative and quantitative KPIs aligned with targets, and a seamless data collection process for all decarbonisation actions. Sustainability needs to be embedded in decision-making. The business plan template needs to capture sustainability from decarbonisation and climate risk perspectives and should be given appropriate weight. Climate Impacts Given the nascent stage of climate adaptation in UHB, it needs more resources to be properly explored and established. As climate risk exacerbates all existing risks, it ultimately strains UHB's finances in the future if not acted upon appropriately now. Climate Impacts needs to be included in appropriate risk registries, and risk thresholds needs to be set.	A working group or delivery group needs to be established, comprising staff who are owners of decarbonisation actions, to highlight progress and barriers.

Strategic Risks – Sustainability

Risk Post-Controls and Mitigation		
Impact: 4	Likelihood: 5	Net Risk: 20

Actions

What	Lead	By	Update
The 25/26 Quality Improvement and Efficiency Plan has been developed as part of the 2025-26 financial plan	Catherine Phillips/ Paul Bostock	Ongoing during 2025-26 Financial Year	SLT will continue to monitor the 'go further options' for the UHB. Each Clinical Board will present to SLT for 30 minutes each month on how they have progressed toward their 2025-26 QIEP targets following rapid planning events in December 2024 and April 2025. A monitoring function for all plan aspects has been developed and is being utilised in the Finance & Performance Committees during 2025-26. The monitoring reports also support all other fora in which the QIEP delivery is being discussed and supported.
The emission gap between the health board's current emission pathway and targets set by the Welsh government and the SOFW strategy is widening. Hence, the emission reduction targets, and pathway need to be reviewed.	Catherine Phillips	September 2025	A Sustainability Program Board has been established to review and monitor progress of decarbonisation actions.

Report Title:	Quality Committee – Chairs Report			Agenda Item no.		6.6.1	
Meeting:	Board		Public	X	Meeting Date:	25.09.2025	
			Private				
Status:	Assurance	X	Approval		Information		
Lead Exec:	Director of Corporate Governance						
Report Author:	Corporate Governance Officer						

Background and current situation:

The purpose of this report is to highlight the key issues which were raised and discussed at the Quality Committee meeting held on the 5th August 2025.

The papers to this meeting, outlining all of the detail on the below items, can be found on the Cardiff and Vale UHB website linked here.

The minutes from this meeting are linked here.

A recording of the meeting can be found by clicking here.

Executive Director Opinion and Key Issues to bring to the attention of the Board

The Committee considered a number of important items of business at the meetings and a brief synopsis of some of the items discussed are set out in this Report.

CD&T Clinical Board Assurance Report: - The Committee were presented with a patient story about a woman who suffered a sudden stroke and was rapidly brought to hospital, where she received thrombolysis and a mechanical thrombectomy. Her story demonstrated the transformative impact of the new thrombectomy service and the importance of rapid, multidisciplinary care.

The Committee discussed the thrombectomy service and noted that the service hours were expected to expand from April 2026. Clinical teams were refining the details to ensure all parts of the service could scale sustainably, including growing the stroke team at the front door in parallel with radiology.

It was suggested that the Clinical Board provide a future update to the Committee on the proportion of eligible stroke patients receiving thrombectomy, including benchmarking data, performance data, and trajectory. It was noted that the SSNAP database benchmarked nationally and allowed for patient-level analysis.

The Committee was presented with the Assurance Report which detailed the clinical governance arrangements within the Clinical Board in relation to Quality, Safety and Patient Experience (QSPE) agenda over the past 12 months. It outlined the achievements and innovations leading to improved quality and care for patients and described some key challenges, risks and the mitigations in place to continue into 2025/26.

The Committee discussed the radiology team's exploration of alternatives to MRIs under general anaesthetic and the introduction of a "sleep list" approach. Whilst it was still early, teams were continuing to evaluate their findings.

The Committee discussed an incident where a baby sustained a burn injury in a community setting. The need for clearer accountability, better risk assessments, and clear responsibilities was highlighted.

Quality Indicators Report: - The Committee were presented with the Quality Indicators Report and slides which provided assurance in relation to several quality, safety, and patient experience priorities.

The Committee noted some positive steps and early signs of improvement in patient outcomes from obstetric events, which included: enhanced CTG interpretation through All-Wales PROMPT training, improved risk assessments via Badgernet, and increased engagement and openness with families.

The Chair praised the new format of the Quality Indicators Report.

Invited Service Review (IRS) of Cardiff and Vale University Health Board (UHB) Mental Health Services: - The Committee were presented with slides which provided an update on the progress on the improvement plan made in response to the Royal College of Psychiatry Review, which included improvements in risk assessments, therapeutic engagement, and family contact.

The Committee noted that the Mental Health Clinical Board were bringing in extra leadership support to review their models of care, particularly how inpatient and community services were organised.

The Committee discussed co-production, and it was noted that the team was working with Caniad to identify individuals with lived experience who could support. They had a diverse group of family members and service users who provided valuable insights, who would shape how they developed policies going forward.

Equity, Equality, Experience and Patient Safety Action Plan - Six Month Update: - The Committee were presented with a six-month update on the progress, achievements, and ongoing challenges of the Equity, Equality, Experience and Patient Safety Action Plan.

It was noted that data availability and collection remained major challenges. The Welsh Index of Multiple Deprivation was regularly updated and used for analysis. Teams had been asked to review waiting lists using this index to identify disparities. However, data gaps remained—while postcode and sex were well recorded, disability, ethnicity, and other protected characteristics were often missing.

Theatres Review: The Committee were provided with the following update:

- A full improvement plan with 66 actions had been submitted to the Cabinet Secretary and Health Inspectorate Wales (HIW).
- The focus for this meeting was on the progress with six foundation actions and high-impact tranches. Other recommendations were scheduled for later phases.
- Good progress had been made despite summer pressures and staffing demands.
- Staff had been hard on themselves, but key issues had been addressed. A staff sense-check was planned for September to ensure the plan felt coproduced. Some actions required immediate implementation, whilst others needed staff engagement.
- They needed to work on what the main Key Performance Indicators (KPIs) would be to measure success.

Minutes from Clinical Board QSE Sub-Committees / IP&C Group: - The Committee noted the Clinical Board QSE Sub-Committee and IP&C Group minutes.

Recommendation:

The Board is requested to:

a) **Note** the contents of the report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**		Providing Outstanding Quality 2. **Click the objective above to view more detail.**	X
Delivering in the Right Places 3. **Click the objective above to view more detail.**	X	Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered

Prevention		Long term		Integration		Collaboration	X	Involvement	X

Quality Impact Assessment Completed?

Yes –		No –	X	n/a

Impact Assessment:

Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*

Committee/Group/ Exec	Date:

Report Title:	Digital & Infrastructure Committee – Chair's Report				Agenda Item No:	6.6.2	
Meeting:	Public Board		Public	X	Meeting Date:	25.09.2025	
			Private				
Status **(please only tick one)**	Assurance	X	Approval		Information/Noting	X	
Lead Executive Title:	Director of Corporate Governance						
Report Author Title:	Corporate Governance Officer						

Main Report
Background and Current Situation:

The purpose of this report is to highlight the key issues which were raised and discussed at the Quality Committee meeting held on the 12th August 2025.

The papers to this meeting, outlining all of the detail on the below items, can be found on the Cardiff and Vale UHB website linked here.

The minutes from this meeting are linked here.

A recording of the meeting can be found by clicking here.

Executive Director Opinion & Key Issues to bring to the attention of the Board:

The Committee considered a number of important items of business at the meetings and a brief synopsis of some of the items discussed are set out in this Report.

Estates Risk Register

The following points were highlighted on the estates risk register:

- Each department maintains its own risk register, which was consolidated into the overall Capital Estates and Facilities risk register.
- At the time of reporting, there were over 70 risks in the highest (20 plus) category and 153 in the amber category, which reflected the age and condition of the estate.
- The risk register is used to prioritize spending and to select top risks for funding bids and capital investment.
- The team is transitioning from their previous system to the AMaT system for risk management, which is taking some time.
- drone surveys were conducted to assess the condition of roofs and water goods.
- The roof above the theatre block at UHW, is a copper roof above the plant rooms, which has significant damage and corrosion.
- Operation Poet involved a complete power outage exercise, first conducted at UHW in 2023 and extended to UHL in 2024. Further exercises planned for September & October 2025.
- The replacement of a main switch panel (sub 2A) at UHW, serving theatres and laboratories, required significant planning and coordination with clinical teams, and would be completed in time for Operation Poet.
- Solar panels were installed covering the 2 lower levels of the car park at UHL.
- Similar solar canopy arrays were being installed at UHW, with completion expected by October, contributing to energy savings and reduction of the carbon footprint.

Strategic Priorities 2025/26

The following points were highlighted for the strategic priorities 2025/26:

- The need to align strategic work and portfolios was highlighted with the board's strategy for infrastructure, including digital, and referenced the earlier presentation as a practical example of how operational detail feeds into longer-term goals.
- The importance of understanding whether the organization is delivering on its annual plan and moving toward long-term objectives was emphasized, not just reacting to immediate problems. The digital roadmap is on the agenda, but an estates roadmap is not yet in place, though an ideal estate strategy has been presented to the board.
- The digital and infrastructure must respond to population needs, partnership work, and modern technologies, which may reduce the need for physical infrastructure.
- This agenda slot should regularly check if the committee is covering strategic progress, in-year priorities, and the long-term path, and invited feedback on this approach, with plans to bring it back to the agenda next time.

Digital Roadmap & Work Programme Update

The following points were highlighted on the digital roadmap & work programme update:

- The team conducted over 70 workshops and meetings to co-produce the plan, and the first draft of the five-year roadmap now available, with identified barriers being both cultural and technological.
- The high-level programme business case and business justification cases are in draft, with the year 1 BJC expected to include electronic observations, clinical notes, test results, e-referrals, and supporting infrastructure. Consideration is being given to including EU workstation replacement and patient communications, though the latter depends on the NHS Wales app.
- Next steps include concluding data gathering, validating benefits, prioritizing years two to five, and ensuring alignment with Capital Estates and Facilities. There are ongoing discussions with Welsh Government and the interim Chief Digital Information Officer of Wales. The team is also refreshing the digital strategy to include target operating models for both services and implementation.
- Key risks include funding uncertainties, WG plans for a national electronic health record, and the organization's low digital maturity. Concerns from workshops include training and upskilling, which are being addressed with the People and Culture plan.
- The capital ask is estimated at £20–25m over five years, with the focus on additionality rather than backlog funding. The governance plan outlines the internal and external approval process, aiming for public board sign-off.
- Draft roadmaps and high-level timelines for years one to five were mentioned, with details to be shared after the meeting.
- Two appendices were referenced: one updating on annual plan items and another providing a tactical update on current activities outside the strategic work programme.

Corporate Digital Risk Register

The following points were highlighted on the corporate digital risk register:

- The one risk that remained red status was cyber security
- Other risks were in yellow status, with scores between 8 and 9, and there are no changes to these.
- It was suggested to close the risk relating to effective resource utilisation, explaining that the digital services management process has been adjusted to better prioritise and

deprioritise competing priorities, allowing the team to manage organisational needs more effectively.

Information Governance Data Compliance

The following points were highlighted on the information governance data compliance:

- The IG department was resourced at five whole time equivalents (WTE) and continues to review a large number of health board IG-related incidents, with 116 incidents reviewed between May and June. Of these, three met the threshold for reporting to the ICO, detailed in private papers.
- Freedom of Information (FOI) compliance remains largely unchanged at 61 and 91% per month, respectively.
- Medical records request compliance increased to 37%, with a month-on-month rise since November, but still below acceptable levels. There are about 305 requests per month.
- Non-health records requests were compliant for 18 out of 19 requests between April and May, with most requests from staff being wide in scope and complex.
- For the National Intelligence Integrated Audit Solution, nearly 1,200 letters have been sent to staff regarding their access to clinical systems.
- Mandatory IG training figures have increased slightly to 72% for health board staff, and a trend graph was provided for the last 12 months per clinical board, with a breakdown by staffing group available if needed.

The minutes from the digital directors peer group from May, June & July 2025 were noted.

Appendices (please list all appendices that accompany this report. Do **not** embed)

Recommendations:

The Board/Committee (delete as appropriate) is requested to:

a) **Note** the report

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "x" in the below boxes where relevant – *Click each item for further information.*

1. Putting People First	x	2. Providing Outstanding Quality	x
3. Delivering in the Right Places	x	4. Acting for the Future	

Five Waves of Working (Sustainable Development Principles) considered:
Please place an "x" in the below boxes where relevant

Prevention		**Long Term**		**Integration**		**Collaboration**	x	**Involvement**	x

Quality Impact Assessment Completed?
Please place an "x" in the below boxes where relevant

Yes		No (please provide reasoning e.g. not required		Not required

Impact Assessment Please place an “x” in the below boxes where relevant
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No - *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:

Report Title:	Mental Health Legislation Committee – Chairs Report			Agenda Item no.		6.6.3
Meeting:	Board		Public	X	Meeting Date:	25/09/2025
			Private			
Status:	Assurance	X	Approval		Information	
Lead Executive:	Director of Corporate Governance					
Report Author:	Corporate Governance Officer					

Background and current situation:

The purpose of this report is to highlight the key issues which were raised and discussed at the Mental Health Legislation Committee meeting held on the 26th August 2025.

The papers to this meeting, outlining all of the detail on the below items, can be found on the Cardiff and Vale UHB website linked here.

The draft minutes from this meeting are linked here.

A recording of the meeting can be viewed by clicking here.

Executive Director Opinion and Key Issues to bring to the attention of the Board:

The Committee considered a number of important items of business at the meetings and a brief synopsis of some of the items discussed are set out in this Report.

Mental Capacity Act Monitoring Report and DoLS Monitoring: - The Committee were presented with the report which provided a general update on current issues related to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The MLA and DoLS indicators included, but were not limited to:

- Mental Capacity Act Monitoring Actions (April - June 2025)
- Mental Capacity IMCA Referral type
- Awareness Raising / Training Sessions
- Mandatory MCA Training
- MCA Practitioner Led Training – 2024/25
- MCA Team Advice and Support
- MCA Team Resources for Staff
- Deprivation of Liberty Safeguards Monitoring Actions
- Referrals and Assessments
- Other Business

It was suggested that future reports include a further breakdown of IMCA referrals by age, specifically for the 65+ category.

Regarding the training programme, the Committee were informed that 10% of people still did not feel confident applying the MCA principles in practice, and that it was common across all areas. To tackle this, they reassured staff during training that support was always available and encouraged people to reach out with queries.

Mental Health Act Monitoring Exception Report: - The Committee were presented with the Mental Health Act (MHA) Monitoring Exception Report to the Committee which provided a summary of the below:

- Use of the MHA
- Fundamentally defective applications and reports
- Section 136 - A&E and CAMHS
- Nearest relatives discharge requests
- Development sessions
- Audits

The Committee were provided with a summary of the following reported during the quarter:

- No fundamentally defective applications or reports
- 1 lapse of Section 5(4)
- The use of Section 136s had increased

The Committee discussed the fact that CAVUHB had seen an increase in nearest relative discharge request compared to other UHBs, and the reasons behind this were unclear. It was suggested that it could either mean that relatives were well informed, or that the UHB was not managing expectations effectively. It was agreed by the Committee that the Executive Nurse Director would discuss this issue with the mental health team.

The Committee suggested that the team look into the possibility of auditing cases where patients are discharged with no follow-up after a Section 136 assessment, to provide assurance that nobody would slip through the net.

Mental Health and Wellbeing Strategy / Suicide and Self-Harm Prevention Strategy – Verbal Update: - The Committee were provided with the following verbal update:

- The new strategy went live in April 2025.
- CAVUHB was working with 36 Degrees to align and role model the service with the strategy.
- Work would continue until March 2026 and would work with colleagues across Wales to contribute to an All-Wales approach.

MHA / DoLS Interface – Verbal Update: - The Committee were provided with the following summary:

- The team had met to discuss the issue of general wards being unsure how to manage the Mental Health Act (MHA), especially when DoLS applied.
- They would be undertaking some fact-finding with wards to identify what sort of information would be helpful – potentially a booklet with guidance on the MHA, DoLS, and contact details for the team.
- They were due to reconvene in six weeks to discuss the findings.

The Committee noted that the booklet would outline with the MHA applied, why DoLS might not, and include guidance on arranging assessments and key contacts.

Section 12 Challenges and Futureproofing – Verbal Update: - The Committee were provided with the following summary:

- A survey had been circulated because many long-standing Section 12 doctors were retiring or stepping back from night shifts, leaving them short on overnight and weekend cover.
- The survey explored their experience, priorities (e.g. DoLS vs mental health assessments), and whether they would recommend becoming Section 12 doctors.

- Responses were mixed, but the main issue raised was the fee – it had remained unchanged since 2005 and no travel reimbursement was made from the UHB (unlike some other UHBs).
- They were looking at ways to retain and recruit Section 12 doctors, including how assessments were arranged. Currently, AMHPS relied on a long spreadsheet with contacts, but the Local Authority (LA) was trialling an app to streamline this. They needed UHB approval to start a free one-year trial, with future costs to be considered.
- Another challenge was that Approved Mental Health Professionals (AMHPs) often chose assessors they were familiar with, which could affect the independence of the process.

Regarding the app, the Committee were informed that they were still waiting to confirm the ongoing costs after the initial trial period. However, it looked like an efficient tool to help improve their processes

Board Assurance Framework (BAF): - The Committee noted that the BAF had been added to all agendas for UHB Committees for discussion. It was agreed that the BAF would not come to the Mental Health Legislation Committee as a standing item, as relevant strategy elements would be captured under strategic risks and brought to the Quality Committee.

Mental Health Bill – Verbal Update: - the Committee were informed that the Bill was currently in the House of Commons at the report stage. Once this was complete, it would move to the third reading and then final amendments.

Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report: - The Committee was presented with the Monitoring report which provided further information on the UHB Mental Health Measure performance. The performance measures included, but were not limited to:

- Part 1a - target: 28-day referral to assessment compliance target of 80% (Adult) and (Children & Young People)
- Part 1b – 28-day assessment to intervention compliance target of 80% (Adult) and (Children & Young People)
- Part 2 – Care and Treatment Planning (over 18) and (Children & Young People)
- Part 3 – Self-Referral Assessment Outcomes
- Part 4 – Advocacy Access

Sub-Committee Meeting Minutes: - The Committee received the Sub-Committee meeting minutes for noting.

Court of Protection (COP) Procedure & Guidance: - the Committee approved the COP Procedure & Guidance.

Memorandum of Understanding: MHA/DoLS Interface Guidance: - the Committee supported the document, which would be followed up outside of the meeting by the Director of Corporate Governance, the Executive Nurse Director, and the MCA & Consent Lead.

Recommendation:

The Board is requested to:

a) **Note** the contents of the report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**		Providing Outstanding Quality 2. **Click the objective above to view more detail.**	X
Delivering in the Right Places 3. **Click the objective above to view more detail.**	X	Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term		Integration		Collaboration	X	Involvement	X

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***	X	n/a

Impact Assessment:
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/ Exec	Date:

Report Title:	Audit and Assurance Committee – Chair's Report				Agenda Item no.	6.6.4	
Meeting:	Board		Public	x	Meeting Date:	25.09.2025	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Senior Corporate Governance Officer						

Main Report
Background and current situation:

The purpose of this report is to provide Board Members with a summary of key issues discussed at the Audit and Assurance Committee Meeting held on 2 September 2025.

A draft copy of the minutes from this meeting can be found here and these are to be reviewed by the Committee at the next meeting held in November.

A recording of the meeting can also be viewed by clicking here.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Key areas of discussion:

- **Internal Audit Progress Report:** The Head of Internal Audit (HIA) provided an update, highlighting that nine reports had been finalised, with two receiving limited assurance.

  The committee was pleased to note improvements in management response times to audits, a significant step forward from the previous year. However, the Quality and Safety Governance audit faced delays due to its complexity but was expected to be completed by November 2025.

  The committee also discussed follow-up audits on Alcohol Standards (Limited Assurance) and Cybersecurity Governance (Limited Assurance), with ongoing issues and proposed improvements highlighted by the audit leads.

  Internal Audit Reports discussed:

  - Alcohol Standards Follow-Up
  - Cybersecurity Governance
  - Microsoft 365 Benefits Realisation Audit
  - Therapies and Health Sciences Agency Additional Hours and Overtime Audit
  - Waiting List Management Audit
  - Surgery CB Governance Arrangements
  - Contract Management Advisory Audit
  - Medicine Clinical Board Acute Medicine Model Audit
  - Integrated Annual Plan Audit

- **Audit Wales Update**: The Audit Manager (AM) informed the Committee that the current period was relatively quiet for Health Board financial audit work, with the Charitable funds audit scheduled for November 2025, well ahead of the Charity Commission deadline of January 2026.

  The Audit Lead from Audit Wales (ALAW) mentioned that the Planned Care review was complete and on the agenda for discussion, with the Performance Audit Manager, set to present the findings later in the meeting. Other reviews were at various stages: the eye care services

review was at the reporting stage, fieldwork was underway for the structured assessment and digital transformation review, and the project brief for the clinical coding follow-up review had been issued. Additionally, estate management deep dive and local council reviews were at the planning stage.

The ALAW also highlighted that exhibit 3 in the update paper provided links to recent national reports, including a cost savings arrangements checklist for Board members. This checklist was intended to help Board members scrutinise and assure themselves of effective cost savings arrangements within the Health Board.

The committee suggested that the checklist be circulated to the Corporate Governance team, Board, and Clinical Board leaders to support savings monitoring and engagement.

- **Post Payment Verification End of Year Report for 2024/25**: The All Wales Post Payment Verification Manager provided an update on the PPV activity for the year 2024/25. The report highlighted a significant workload due to a high number of General Medical Services (GMS) revisits. Out of the 54 planned visits for the Health Board, only 38 were completed. This shortfall was attributed to unexpected staff absences and the complexity of revisits triggered by small sample sizes and a new payment system.

  Despite those challenges, additional service checks were introduced, and the team managed to catch up on overdue work in the first quarter of 2025/26. Efforts to recover overdue work and improve reporting were emphasised, including the introduction of training sessions and video guides for practice managers.

  It was suggested that future reports should provide more context for Committee members, especially new ones, by explaining the purpose, importance, and implications of PPV work. Additionally, the data should be contextualised to indicate whether results were above or below average and what the findings meant for the organization.

- **Procurement Compliance Report**: The Deputy Director of Finance presented the Procurement Compliance Report, highlighting a concerning trend of increasing non-compliance cases, particularly in the areas of capital estates and emergency maintenance. These areas often required urgent procurement, which sometimes led to bypassing standard processes.

  The report noted that there had already been 53 breaches in the current year, compared to 63 for the entire previous year. However, it was cautioned that many contracts were signed early in the year, so the trend may not continue at the same rate.

  To address these issues, training sessions were being scheduled for areas with high non-compliance, and a deep dive on procurement compliance was planned for the next Audit Committee meeting. The need to monitor the effectiveness of training and to see if non-compliance improved as a result was emphasised.

- **Structured Assessment Update:** The report showed that actions and recommendations from the last assessment were being addressed, with one action remaining outstanding: the need for a new risk management strategy.

  It was noted that the outstanding action was delayed because the risk management strategy and policy must follow the ongoing work to transfer all organisational risks into AMAT, as the team were still learning and building the module with the vendor.

- **Tackling the Planned Care Challenges**: The Committee discussed the challenges in Planned Care in detail.

It was noted that the report was part of a national thematic programme across all Welsh Health Boards and that the findings highlighted that despite operational improvements, Cardiff and Vale's approach had not achieved the desired impact on waiting lists and that recent improvements may not be sustainable due to reliance on short-term Welsh Government funding

The report emphasised the need for a longer-term, sustainable plan for clinically and financially viable services, as demand and waiting lists had grown over several years, not just post-pandemic.

While some efficiency improvements were noted, more were needed. The importance of supporting patients while they waited, especially to prevent harm, was highlighted.

The report outlined nine recommendations, acknowledging that some actions would take until 2026 to fully implement. The preference was for robust, embedded solutions over quick fixes.

The Vice Chair of the University Health Board raised the need for more specificity in clinical risk analysis, emphasising that harm was not just about long waits but about urgency and pathway management.

The Managing Director of Planned Care added that clinical validation during waiting was being embedded, starting with ENT and expanding to other specialties, with consultant and therapist time allocated for patient reviews.

- **Items to be Deferred to Board/Committee:** Internal audit reports specific to committees of the Board would be added to the relevant committee agendas where appropriate.

Recommendation:

The Committee is requested to:

a) **Note** the contents of this Report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

Putting People First	x	Providing Outstanding Quality	x
Delivering in the Right Places	x	Acting for the Future	x

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: No

Safety: No

Financial: No

Workforce: No

Legal: No	
Reputational: No	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	**Strategic Planning, Commissioning and Partnership Update**			Agenda Item no.	6.7
Meeting:	Public Board	Public	X	Meeting Date:	25.09.2025
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive Title:	Executive Director of Finance & Interim Executive Director of Planning Executive Director of Allied Health Professionals, Health Scientists, Community Services Development				
Report Author (Title):	Executive Director of Finance & Interim Executive Director of Planning Executive Director of Allied Health Professionals, Health Scientists, Community Services Development				

Main Report
Background and current situation:

This report provides the Board with an update on key areas of strategic planning, commissioning, and partnership work programme. Its purpose is to give the Board assurance that actions agreed in our annual work programme or Annual Plan are being progressed and risks around delivery are being managed - it includes relevant updates in relation to the following areas:

- Strategy development and delivery
- Integrated Medium Term Plan (IMTP)/Annual Planning
- Regional and tertiary services planning work programme
- Engagement for service change
- Commissioning
- Partnership planning

Executive Director Opinion and Key Issues to bring to the attention of the Board:

1. Strategic Portfolios and plans

A strategic executive away day was held 12th September as the second meeting of the steering committee. The senior responsible officers (SRO) presented on portfolios scope and strategic alignment, impact, emerging priorities, key risks and dependencies which gave opportunity for discussion and challenge.

The strategic portfolios will inform the workplans for the Strategic Planning team going forward in addition to corporate planning responsibilities. Updates on specific aspects of planning are shared through this report, but an overview of all portfolios will be included within a separate board report this month.

Alongside strategic programmes, several plans and their development will be included within the scope of the portfolios. These include Population Health, Infrastructure (estates and digital), People and Culture and Clinical Services Plans.

The development of a Clinical Services Plan is one of the criteria for de-escalation from level 4 in the Planning domain and as such has been accelerated internally. An Executive oversight group has been established, to oversee the development of the plan and effective co production and engagement chaired by the UHB Vice Chair.

This has been discussed at the Strategic Leadership Team and will be presented to the Quality Committee 16th September.

2. Annual Planning

2i. 2025/2026

On 31 March 2025, the Health Board submitted its Annual Plan for 2025/2026 to Welsh Government, which included a £30 million savings ambition to achieve a forecasted £58.2 million deficit. The plan fell short of the £9.1 million financial control total set by Welsh Government, leading to its return on 11 April as "unsupportable and unacceptable."

The Senior Leadership Team are clear on the scale of the challenge and continue to track progress against the savings plan through weekly SLT meetings.

The Board will receive in year assurance on plan delivery at Quarters 2, 3 and 4

2ii 2026/27

The Board has agreed its approach to plan development for 26-27 (Board development session, August 2025). An approach which sets the focus on developing an 'acceptable' annual plan, which is underpinned with clear planning parameters, assumptions and expectations from the outset, sets a clear approach to plan delivery; ownership and accountability and finally a plan that has a refreshed design and layout that reflects feedback on the current document style and accessibility.

The Board also agreed in August, five priorities that need focusing on within the plan. These priorities are reconfirmed below.

- Agree the blueprint (with partners), and commence implementation of, an ICCS as our new organisational form. Ensuring the model describes a spectrum of services from prevention, primary and community services through to tertiary that our population can seamlessly move through as and when their care needs change.
- Engage and build well across our organisation and our partnerships from community through to tertiary to ensure a renewed focus on prevention and reducing inequalities when we transform the way we deliver our health and care services.
- Accelerate collaborative working, quality improvement approaches and adoption of best practice to meet our operational demand challenges.
- Implement improvements identified through cultural reviews.
- Deliver ambitious, but realistic and safe, recovery trajectories that display tight cost control, efficiency and good outcomes for patients that support moving the organisation to a sustainable operational, workforce and financial position.

Progress continues to be made with finalising and implementing local Clinical Board and corporate team planning to inform the annual plan with further updates expected for Board in October's development session and November's Board meeting

3. Regional Planning – Southeast Wales *(Shaping our Future Clinical Services Portfolio)*

The priority areas for the South East Wales regional partnership in 25/26 are -

- Progression of Llantrisant Health Park
- Regional Ophthalmology
- A South-Central regional stroke service
- A regional Pathology service- with a focus on microbiology
- Development of a cancer programme for the region

SEW regional Joint Committee

The Board will receive the proposed ToR and associated papers under a separate agenda item. Subject to approval by all partners the joint committee will meet for the first time in October.

RJC partners have recently made an appointment to the post of 'Director SE Wales Regional Collaborative' to support the committee's work.

Llantrisant Health Park (LHP)

The LHP programme have agreed a phased approach to the submission of business cases to Welsh Government. With the first case, an outline business case (OBC) for the Community Diagnostic Hub (including Endoscopy Unit and training facility) for all Boards to consider in September, with a build timetable commencing in March 2026 and concluding at the end of 2027.

An OBC for the elective and orthopaedic facility will then be completed before the end of 2025 supported by a regional plan for Orthopaedics which at this stage is focused on a refreshed demand and capacity exercise, a baseline assessment of workforce and articulation of local UHB plans. The plan will continue to develop ahead of an expected FBC in Spring 2026.The last OBC will focus on a surgical hub facility for CTMUHB. Each phase is designed to build on the previous, with infrastructure and commissioning aligned to regional demand, capacity, and sustainability challenges.

The OBCs are being developed collaboratively by ABUHB, CAVUHB, and CTMUHB, overseen by the Regional Oversight Board.

Regional Ophthalmology

The regional programme successfully delivered its objective of ensuring that as of 31 March 2025 no stage 1 across the region was waiting over 95 weeks and no stage 4 patient was waiting over 104 weeks for cataract surgery. Circa 5000 patients treated through regional capacity and outsourcing. The UHL theatre opened in July ensuring the Ministerial enabling action of 8 cataracts per list has been achieved.
The focus for the next phase of the programme includes;

- Shifting to building a sustainable, long-term NHS cataract service, reducing reliance on outsourcing and private sector support.
- Workforce strategy is being developed, with a comprehensive audit underway to inform future planning.
- Scoping a "Regional Alliance Model", with a pilot for cataracts and plans to expand to other specialties.
- Migration to the Open Eyes EPR (electronic patient record) is progressing, with cloud migration and version upgrades supporting integration and data quality.

Stroke

Cardiff & Vale and Cwm Taf Morgannwg UHB's continue to build on the collectively agreed strategic direction of travel which will focus on working together to (1) maintain an acute stroke service within CTM, and (2) develop UHW as a Comprehensive Regional Stroke Centre (CRSC) for specialised care, including thrombectomy. A regional Operational Delivery Group has been established to oversee the developments and improvements to the acute elements of the stroke pathway. A regional response to the consultation on National Stroke standards has also been submitted.

Pathology

Regional partners recognise that embarking on a significant change programme such as regional cellular pathology modernisation is a significant ask and will require appropriate resourcing. Partners have agreed what the regional desired change management model needs to look like, and further work across planning, finance and operational colleagues is now taking place to understand how this can be implemented in an affordable manner.

4. CAVUHB & VUNHST Partnership (*Shaping Our Future Clinical Services Portfolio aligned to Future Generations Portfolio***)**

A new partnership programme is emerging between CAVUHB & VUHNST to focus on the development and assessment of opportunities for future models of care, across sites in Velindre University NHS Trust and Cardiff & Vale University Health Board. A work programme is being established to identify opportunities for redesigning services to improve patient outcomes, maximising the use of existing estate and ensuring service sustainability in line with national service specifications. The partnership programme will report into the CAVUHB regional planning board and up into the Clinical Services Strategic Portfolio.

5. Regional and Specialised Services Provider Planning Partnership *(Shaping our Future Clinical Services Portfolio)*

The specialised services partnership with Swansea Bay UHB, known as the Regional and Specialised Services Provider Planning Partnership (RSSPPP), continues to meet monthly. Below is a summary of the progress across the provider partnership portfolio:

Hepato-Pancreato-Biliary (HPB) Surgery

- Following the closure of the HPB Programme, Health Boards have been formally advised that due to the absence of a formal commissioning framework and the financial burden of treating out-of-area patients without reimbursement, a short-term interim arrangement based on a prior approval protocol will be implemented which requires referring Health Boards to commit to full cost recovery for each patient. The aim is to provide temporary support to Health Boards, whilst they establish definitive commissioning arrangements for this cohort of patients. Health Boards have been informed that the interim model is not clinically sustainable, as it is currently delivered by a single consultant without a regional MDT.
- There have been ongoing discussions around the potential development of an integrated HPB service for South Wales, West Wales, and South Powys, including recent conversations at the Chief

Executive Management Team and the National Cancer Leadership Board. Further updates will follow as the position becomes clearer.

Specialised Infectious Diseases Services

- The outcome of the multidisciplinary inter-organisational workshop was presented to the RSSPPP on the 15th August. Following a constructive discussion, it was agreed that Specialised Infectious Diseases was unlikely to be considered a priority for commissioners. To ensure transparency and maintain a clear audit trail, the RSSPPP recommended that the current service and the implications of pausing this work be submitted to the Chief Executive Management Team for consideration.

Gynaecologic Oncology Surgery

- The project team has received positive feedback on the communication and engagement plan from Llais for advice. Discussions are ongoing with DHCW regarding the development of a travel time analysis to support the targeted engagement process with service users. The clinical leads have commenced engagement with staff through the MDTs and will be establishing a task and finish group to develop a service specification for the operational delivery network. The first meeting of the Gynaecologic Oncology Surgery Project Board is scheduled for the 19th September.

Cardiac Surgery

As part of the preparation for the forthcoming NWJCC review of Cardiac Surgery, discussions are ongoing with colleagues from Swansea Bay UHB to consider how the two services can collaborate more effectively to improve efficiency and the long term sustainability of the service.

Governance

- The RSSPPP has approved an updated terms of reference for the group, which include further information about shared financial responsibilities, risk management, and monitoring of outcomes.

6. Commissioning

NWJCC

The NWJCC commissioning groups and provider SLA interface meetings have not yet been established. The commissioning and contracting teams continue to work closely with colleagues in the clinical boards, strategic and operational planning to ensure appropriate representation from across the organisation ensuring these individuals are included in the monthly commissioning group meeting and are responsible for providing appropriate briefs ahead of commissioning and provider SLA meetings.

The NWJCC IMTP process doesn't currently include a mechanism for engaging with providers on emerging service pressures and system fragility. Ideally a dialogue with providers would have taken place to inform priorities and proactively manage risk prior to its issue. There are also concerns that this is the second consecutive year

without any new investment, which undermines the ability to plan strategically for sustainable service delivery.

The NWJCC have indicated an intent to disaggregate non-specialised plastics commissioning to the Health Board. They propose a shift in plastic surgery commissioning from NWJCC to local Health Boards, with the rationale that most procedures are non-specialised and better managed locally. Changing this model without strong evidence risks destabilising well-established services. A more robust case for change including capacity analysis, coding audits, clinical impact modelling, and a strategic rationale would be beneficial to inform decisions. The UHB recommend retaining current arrangements at this time.

The DBS pathway to Bristol has been agreed to reopen, with formal communication expected soon.

Individual Patient Funding Requests (IPFR)

Recruitment is underway for the maternity cover of our IPFR Commissioning Officer. The role was deemed as essential due to the statutory nature of the IPFR function.

The IPFR Policy was approved at the NWJCC Joint Committee meeting (subject to amendments in Appendix 1) and being prepared for consideration at the Board in November.

Following on from an action at SLT, an IPFR paper has been produced for October SLT which includes historical funding details.

7. Engagement for Service Change

Clinical Services Plan

The main focus of engagement work until the end of the year will be around the clinical services plan - “Shaping Services for the Future, Together”.

The 20-week engagement period launched in August and will run until the 18th December. To date, we have received almost 1000 responses.

The engagement includes two online surveys – the question to both were co-produced with our internal co-production group.

We have a programme of over 30 community events to attend until the end of the engagement phase, this includes:

- Cardiff and Vale College Freshers Fair (Cardiff & Barry Campus)
- Cardiff University Freshers Fair
- Cardiff Met Freshers Fair
- USW Cardiff Campus Freshers Fair
- Visits to Mosques
- Visits to Churches
- Visits to Food Banks
- Community drop in events at hubs and libraries
- Visits to a local Gypsy Traveller site

We have been successful in a bid with the health charity to support the engagement activity, this includes working with the third sector to facilitate focus groups with minority ethnic communities across Cardiff and VoG. The bid has also enabled us to translate the survey into multiple languages.

Our focus during this period of engagement is ensuring that we reach parts of our community that we do not usually engage will effectively. This includes ethnic minority groups, people who live in areas of socio-economic deprivation, the gypsy traveler community and we are working with CAVHIS to ensure we reach the homeless community, asylum seeks and other vulnerable groups.

For each chapter of the plan we are holding "spotlight" sessions to enable the public to attend and give their feedback for particular service areas.

In October, we will be working with the hospital radio to record sessions discussing the plan and how the public can help shape it. This will be broadcast live, with recordings of the session available for members of the public to listen to at a later date and provide feedback.

8. Cardiff & Vale Regional Partnership Board *(Shaping our Population Health and Place Based Partnerships portfolio)*

The Health Board continues to play an active role in the Regional Partnership Board (RPB) and over the last quarter there has been a focus on the following areas:

Phase 1 of developing an Integrated Community Care System is in progress and focusing on delivery of four main workstreams:

- Development of an Urgent Care Centre in Barry Community Hospital
- Development of the community hospital and community bed model as part of the suite of resources supporting people to remain in their communities
- Development of our crisis response capability to prevent avoidable admissions to EU and hospital, including an integrated delivery model for responding to falls and reducing the number of level 1 and 2 falls attending the EU
- Development of our 'connected communities' model of care, delivering proactive coordinated care closer to home for individuals with complex need

The first phase of this is under development and will be overseen by the Population Health and Places portfolio. Support to articulate and develop the 2nd phase of the ICCS will be commissioned by the Health Board to embark on this significant transformational journey. A partner-wide summit is planned for late Autunm to build consensus on the Region's ICCS ambitions and the contribution of each partner.

An overview of the achievements of the RPB can be found in the Annual report for 24/25 here (https://cavrpb.org/app/uploads/2025/06/Annual-Report-2024-25-Final-PDF-compressed-1.pdf) . The Annual Delivery Plan for 25/26 has been approved and is available on request from hsc.integration@wales.nhs.uk

Recommendation:

The Board is requested to:

(a) **Note** the progress being made across the Strategic Planning, Commissioning and Partnership portfolio

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please place an "X" in the below boxes as relevant.*			
Putting People First 1. **Click the objective above to view more detail.**	x	Providing Outstanding Quality 2. **Click the objective above to view more detail.**	x
Delivering in the Right Places 3. **Click the objective above to view more detail.**	x	Acting for the Future 4. **Click the objective above to view more detail.**	x

Five Ways of Working (Sustainable Development Principles) considered *Please place an "**X**" in the below boxes as relevant*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Quality Impact Assessment Completed?: *Please place an "**X**" in the below boxes as relevant. A blank QIA and guidance on how to complete a QIA can be found by clicking the link here:* ***Quality Impact Assessment Information***				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		*Comment here*

Impact Assessment: *Please state **yes** or **no** for each category.* ***If yes please provide further details.***
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No

Decarbonisation: No	
Welsh Language: No	
Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

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<tr><td>Report Title:</td><td colspan="3">Ministerial Advisory Group Report Update</td><td colspan="2">Agenda Item no.</td><td colspan="2">6.9</td></tr>
<tr><td rowspan="2">Meeting:</td><td colspan="2" rowspan="2">Board</td><td>Public</td><td>X</td><td rowspan="2">Meeting Date:</td><td colspan="2" rowspan="2">25/09/25</td></tr>
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<tr><td>Status:</td><td>Assurance</td><td></td><td>Approval</td><td></td><td colspan="2">Information</td><td>x</td></tr>
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<tr><td>Report Author:</td><td colspan="7">Director of Operational Planning and Performance</td></tr>
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Background and current situation:

The Ministerial Advisory Group (MAG) on Performance and Productivity was an external independent expert panel commissioned by the Cabinet Secretary for Health and Social Care to undertake a review of the Performance and Productivity in NHS Wales. Its recommendations, published on 29th April 2025, were largely accepted by Welsh Government and there has been national and local focus on delivery over the last 5 months.

Full details of the process, context and outputs of the MAG were presented to Board in May 2025. The MAG was comprised of a range of clinical and operational leaders from across the NHS in England and Wales. The group aimed to ensure its work was clinically led, data driven and evidenced based. The MAG engaged with a number of stakeholders across NHS Wales, this included a visit to the University Hospital of Wales in Cardiff on 22nd January 2025.

This paper provides an update on the progress against those actions for which the Health Board was fully or partly responsible for delivery. In total there are 29 recommendation (34 individual actions) each with a timescale of between 3 and 12 months. Welsh Government accepted all of the recommendations – 23 in full, 11 in-part. Cardiff and Vale have full or part responsibility for delivering 17 of the recommendations.

On reviewing the MAG recommendations, it was evident that many were already in progress within Cardiff and Vale. Established programmes, such as 6 Goals for Urgent and Emergency Care and the Planned Care Portfolio Board, have been in operation for some time and the areas of focus within these board were closely aligned with the MAG recommendations. Delivery has therefore predominantly been owned within either these programmes or directly within the operational and corporate teams; no additional or duplicative governance processes has been established.

The enclosed appendix provides detail on progress against each of the MAG recommendations for which the Health Board have involvement. The appendix includes detail of actual measurable performance, where it is available, alongside an indicative RAG rating and some key points of note.

Planned Care

Progress on planned performance has been mixed. It is positive that referrals, across nearly all high-volume specialties, have been lower than the average from the previous year. In specialties such ophthalmology this has been achieved by the wider rollout of Wales General Ophthalmic Service (WGOS) 4 and joint working between primary and secondary care. The Health Board continues to increase the number of HealthPathways in place which provide advice and guidance to general practice.

Operational focus within outpatient services has predominantly been directed to delivering the national insourcing clinics in order to deliver over 36,000 additional new appointments by the end of March 2026. Whilst this has reduced capacity for delivering some aspects of our transformation plans, increasing the % of SOS and PIFU outcomes from outpatient clinics remains an organisational focus. The foundation work has now been completed and a new, simplified, Clinical Outcome Form will launch at the end of the September. This year we have worked on a treat in cohort basis for our longest waiting patients - the managing director for planned care receives a daily view of the % of patients in the 2-year cohort booked and the team regularly review booked lists, working with specialties to substitute long waits into lists where appropriate. This work has commenced across all specialties, but with a particular on the areas with the largest opportunity, namely Ophthalmology and Orthopaedics

Overall theatre utilisation is slightly above 24/25 baseline despite challenges with late starts and early theatres. Much of the focus within our theatres has been the delivering of the Theatre Together Programme, working to address the culture and operational shortcomings identified in our recent review. Later tranches of this work include a focus on theatre utilisation so this, combined with our ongoing work with the Surgical Hub at Llandough, will deliver measurable improvements moving forwards.

Diagnostics

We continue to work closely with our partners across the region to develop plans to address backlogs and fragility in services such as endoscopy and pathology. Within endoscopy we have submitted the regional plan to support the development of the Llantrisant Health Park. Within pathology, our regional programme comprises for five projects. Project one focuses on standarisation across organisations and is progressing well. The initial planning work and scoping for projects two and three, which will consider a single management model and a single site option, is underway.

Whilst the MAG report was largely written generically, with the recommendations being applicable to all Health Boards or national entities, it should be noted that there is one which is solely the responsibility of Cardiff and Vale:

Recommendation 8
Cardiff and Vale University Health Board should be required to submit a clear plan detailing how it intends to clear its Non-Obstetric Ultrasound backlog over the course of 2025/26. Timescale – within 3 months.

This action is currently green with the plan on track to eliminate 8 week waits in NOUS by March 2026 and a third insourcing provider commencing in UHL from October 2025.

Cancer

The MAG action for cancer is predominantly aimed at WG, directing them to nationally mandating a set of deliverables drawn from existing policy proposals. Our progress against Cancer is well documented, whilst performance is not yet to the expected standard, we do performance significantly above the rest of Wales and we continue to focus on delivering the national clinical pathway standards.

Urgent and Emergency Care

Cardiff and Vale have made a significant step change in the number of ambulance handovers that exceed 45 minutes, reduce this number from 695 in April to 114 in August. Despite this good progress and maintaining our position as the top performing health board in Wales, we continue to refine and improve our approach with an aim of

achieving 0 > 45-minute handovers. The Health Board continues to work with Welsh Government in relations to audits being undertaken to review the use of the trusted assessor model and we're reporting good compliance with recording D2RA pathways, although there is more work to do with data quality.

Operating Model and Accountability, Productivity and Regional Working

The MAG report detailed a number of additional recommendations, many of which were specifically national entities with a smaller name aimed at Health Boards. These included Health Boards including specific workforce data in board meetings, this has been partially achieved. Additionally, there was a recommendation that Health Boards commission standardised dashboards which has not at this point been considered.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

- The MAG report produced a number of recommendations for both Health Boards and national bodies.
- Cardiff and Vale are delivering the actions within the MAG through our established programmes of work
- Progress on the planned care recommendations are well underway, but this is not, at the current time, translating to significant improvements in performance metrics for areas such as outpatients
- Progress on cancer and diagnostics recommendations are going well and there is confidence in delivery, particularly for non-obstetric ultrasound.
- There has been a significant improvement in ambulance handovers performance

Recommendation:

a) The Board is requested to NOTE the contents of the MAG report update.

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**		Providing Outstanding Quality 2. **Click the objective above to view more detail.**	x
Delivering in the Right Places 3. **Click the objective above to view more detail.**	x	Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term		Integration		Collaboration		Involvement	

Cardiff and Vale University Health Board

Ministerial Advisory Group Update

Board – September 2025

Urgent and Emergency Care

Area	Recommendation	Quantifiable measures	Standard	Baseline (Mar-25 or 24/25)	Actual Performance					RAG	Key points to note
					Apr-25	May-25	Jun-25	Jul-25	Aug-25		
Urgent and Emergency care	Hospitals must endure that all admitted patients are placed on D2RA pathways in line with the national Hospital Discharge Guidance, and delays by pathways should be published within 3 months	D2RA pathway allocated within 1 day of Admission		95% (Mar-25)	95%	95%	93%	97%	95%		Good compliance, further work to improve accuracy of pathway assignment particularly within assessment unit. NHS P&I team are visiting UHB to review pathways on site in October
	Welsh Government should run an audit of use of trusted assessors	N/A									Audit completed in conjunction with UHB - NHS P&I team to produce report. VCRS highlighted a area of good practice - IDS are meeting with Cardiff to look to expand model to CRT team
	A rapid study should be undertaken within 3 months, by Welsh Government working with health boards, to identify which patient groups/pathways consistently experience the longest pathway of care delays, especially when associated with long time spent in emergency departments	N/A									To date no communication has been received from Welsh Government regarding the Audit The patients with the longest inpatient Length of Stay are reviewed in a fortnightly COO-led meeting - this is an operational meeting rather than an audit
	No ambulance handover will exceed 45 minutes, with a focus on achieving the 15 minute target wherever possible	Ambulance holds >45m	0	648 (24/25 av)	695	598	583	578	114		Implementation of additional actions, including ringfenced space in Majors and Assessment Unit to facilitate timely handover

Cancer and Diagnostics

Area	Recommendation	Quantifiable measures	Standard	Baseline (Mar-25 or 24/25)	Actual Performance Apr-25	May-25	Jun-25	Jul-25	Aug-25	RAG	Key points to note
Diagnostics	Welsh Government should create a national plan for endoscopy to address the current backlog of long-waits	N/A								N/A	C&V are supporting the regional endoscopy plan at Llantrisant Health Park with the Outline Business Case being progressed through Cwm Taf governance process during Q3
	Regions should develop a plan to create a regional pathology service which is safe, sustainable and fit for the future	N/A								N/A	We continue to be fully engaged in the planning for regional pathology approaches
	Cardiff and Vale University Health Board should submit a clear plan detailing how it intends to clear its Non-Obstetric Ultrasound (NOU) backlog over the course of 2025/26	NOU 8w waits	0	7371	7733	7420	6711	5990	6177		Plan on track to eliminate 8w waits in NOU by March 2026 - Third insourcing provider to provide appointments in UHL from October 2025
Cancer	No additional cancer performance plans should be produced for 2025/26 and 2026/27. Instead, there should be an immediate focus on implementing a narrow but nationally mandated set of deliverables drawn from existing policy proposals	% of specialties following clinical pathway structure as standard	100%	96%	96%	96%	96%	96%			Breast is the only service currently not clinically aligned to the national optimal pathway due to the absence of 1 stop triple assessment clinic. This has been delayed by the departure of 2 clinical staff members. Planned implementation date October 2025
		First appointment within 14 days	90% (CAV standard)	61%	59%	58%	62%	57%			Performance on pathway components is below standard. Particular focus to be given to appointment within 14-days. All specialities have reviewed capacity against desired standard – some mismatches identified
		Informed they do have cancer within 28 days	80% (CAV standard)	57%	52%	59%	58%	50%			
		Treatment within 21 days of DTT	TBC	65%	62%	68%	73%	68%			
		First Definitive treatment within 62 days	75%	68.7%	59.5%	69.6%	67.0%	68.4%			Best performing Health Board for straight to test

Planned Care

Area	Recommendation	Quantifiable measures	Standard	Baseline (Mar-25 or 24/25)	Actual Performance					RAG	Key points to note
					Apr-25	May-25	Jun-25	Jul-25	Aug-25		
Planned care	Develop a plan to reduce referrals to traditional outpatients in high volume specialities (advice and guidance)	Accepted referrals per month - General Surgery	<24/25	1547	1328	1309	1406	1571	1354		All referrals to high volume specialties lower than 24/25, with the exception of Dermatology. In ophthalmology, which has seen a significant drop, this has been achieved by the wider rollout of Wales General Ophthalmic Service (WGOS) 4 and joint working between primary and secondary care. The Health Board continues to increase the number of HealthPathways in place which provide advice and guidance to general practice. Dermatology - Increase in demand in primary care and referrals to secondary care - this is an all wales trend. Service are working with Primary Care and developing additional advice and guidance criteria for referrals to secondary care. Both Cardiff and Vale have a GP reviewing referrals and redirecting those which can be managed in primary care. Recent pilot of trteatment of BCC below the head and neck in Primary care.
		Accepted referrals per month - Urology	<24/25	450	423	443	455	489	405		
		Accepted referrals per month - Ophthalmology	<24/25	1277	1445	1392	1250	1191	547		
		Accepted referrals per month - T&O	<24/25	2362	2335	2323	2350	2408	2014		
		Accepted referrals per month - Gynae	<24/25	1408	1444	1448	1368	1532	1255		
		Accepted referrals per month - ENT	<24/25	1032	1027	937	956	1019	854		
		Accepted referrals per month - Dermatology	<24/25	824	879	855	1009	1028	992		
	Reduce variation in outpatient waiting times by adopting best practices in outpatient service management (GIRFT / CIN)	SOS/PIFU %	20%	8.3%	7.4%	8.2%	8.4%	8.4%	8.0%		CIN specialties only - current whole health board performance is 4.9%. New simplified Clinical Outcome Form (COF) been developed and will launch at the end of September making it clearer to choose discharge then SOS preferentially
	Better prioritisation of long waits (Treat in Turn) to be a pre-requisite before receipt of additional funding	Treat in Turn	N/A								This year we have worked on a treat in cohort basis for our longest waiting patients - the managing director for planned care receives a daily view of the % of patients in the 2-year cohort booked and the team regularly review booked lists, working with specialties to substitute long waits into lists where appropriate. This work has commenced across all specialties, but with a particular on the areas with the largest opportunity, namely Ophthamology and Orthopaedics
	Welsh Government should set a target for all patients to be validated down to 36 weeks by the end of 2025/26, and introduce a new national dataset to track progress.	Weeks wait validation	36 weeks	90 weeks	78	65	41	40	40		Progress slowed due to support being given to book HBS Insource clinics. No issues with meeting target by end of the calendar year
	Reduce unwarranted variation in treatment waiting times and adopt best practice in theatre management (establish Theatre Optimisation Boards).	Theatre Utilisation (IN)	85%	77%	80%	79%	80%	78%	77%		Overall theatre utilisation is slightly above 24/25 baseline despite challenges with late starts and early theatres. Theatre Delivery Group not currently running and will be re-established later in year. The focus of the team is currently on operational delivery and Theatres Together Programme.
	Seek accreditation for all current Surgical Hubs	N/A								N/A	Accreditation with be sought later in 25/26

Operating Model, Workforce Productivity, Digital and Regional work

Area	Recommendation	Quantifiable measures	Standard	Baseline (Mar-25 or 24/25)	Actual Performance					RAG	Key points to note
					Apr-25	May-25	Jun-25	Jul-25	Aug-25		
Operating Model and Accountability Framework	It is recommended that health boards commission the Welsh NHS Confederation to develop a standardised health board performance dashboard	N/A									The Health Board is engaged in the development of the enabling actions dashboard with WG. At this time, no additional consideration has been given to commissioning a standardised performance dashboard nationally
Measuring Productivity	From the June health board meeting cycle of the 2025/26 annual year going forward workforce head count and productivity data should be reported to the monthly public meeting of the health board	N/A									Workforce headcount is now included in IPR submitted to Board and P&C committee. Currently this excludes GMS data, work is ongoing to correct this. Productivity data currently includes turnover, sickness, job planning. The Health Board is awaiting the national guidance on which further metrics should be included
Regions and Capital	Health boards should work together as regions to identify two priority fragile services to be addressed in 2025/26 and thereafter a further two on an annual and ongoing basis	N/A									These discussions occur within the Regional Portfolio Board. The current focus areas (stroke, cataracts, orthopaedics) are considered fragile. A national fragile services report has been produced, discussions for future years will take place at the planned Regional Joint Committee

Report Title:	Theatres Together – Progress Update				Agenda Item no.	6.10	
Meeting:	Board		Public	X	Meeting Date:	25/09/25	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Chief Operating Officier						
Report Author (Title):	Director of Operational Planning and Performance						

Main Report
Background and current situation:

The Theatre Together Programme continues to deliver on the recommendations made following the Theatre Review which took place during 2024/25. The robust and detailed review uncovered a number of concerning themes, ranging from failures of leadership practice, variable compliance with policies and procedures, and a poor culture all of which is impacting upon behaviours and psychological safety of colleagues.

This paper forms part of the agreed regular updates that will be brought to Board to provide assurance on progress and highlight ongoing risks in relation to delivery against the 66 recommendations in the review. It follows an update on progress which was taken to Board in July which detailed the programme objectives, tranche methodology, governance arrangements, communications approach and key achievements to date. That update also detailed the ongoing risk and challenges, notably the financial impact of delivering some of the actions, and the strained capacity across clinical and operational teams due to staff absence.

At the Board update in July, it was reported that more detailed updates would be provided for all tranches in the next paper. The full action plan is provided as an appendix and in the last two months significant progress has made within the Programme, highlights include:

- A reorganisation of the tranche methodology, bringing forward recommendations from later tranches to capitalise on opportunities for quick wins
- A reorganisation of the reporting to recognise the work that has already taken place within the embedding culture tranche, which was not recognised in previous updates.
- Continued engagement with theatre staff, including an Executive led feedback session in Upper Mains in which the teams acknowledged the progress being made and the further work required
- Scoping for a Theatre Together Dashboard to monitor progress

Embedding Culture Tranche

- Work is underway on all actions, detailed updates provided as part of the report, these actions will run concurrently with all other tranches moving forwards
- People and Culture Task and Finish Group established - initial focus will be on defining roles, responsibilities, and expectations for leaders, especially in light of recent staffing changes and new appointments.

- Given the cultural focus, this tranche will take longer to embed, and timelines will be reviewed in detail during September

Foundation Tranche

- Development of a theatre refurbishment proposal for improving the physical estate, submissions will be made to WG for capital funding in October with an aim to refurbish two theatres within the current financial year.

- Establishment of the theatre cleaning task and finish group – ensuring the revised cleaning proposals are consistent across all theatre suites

High Impact Tranche

- Regular sickness panels have been established with Theatre Managers, Lead Nurse, Director of Nursing and Senior People and Culture Business Partner.

- A range of initiatives have been implemented across all four Perioperative areas to promote staff engagement, recognition, and wellbeing. Shout-out boards have been introduced to showcase staff feedback. Newsletters are used to highlight good practice and achievements, and wellbeing events, including celebrations for Nurses, ODPs, and HCSW as well as events including bake sales and quizzes

- Review of new starter education programme has been undertaken, and education and competency booklets have been further developed to support this approach.
  Work has been undertaken with HEIW to agree funded places for leadership and organisational development, cardiothoracic study days and Facilitated teaching and learning education.

Progression and Transition Tranches

- Despite not formally due to begin until January and April 2026, ongoing actions against many of the recommendations in these tranches are noted within the report. This highlights to fluid and flexible approach being taken to ensure maximum delivery within the programme

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

- There has been good progress against the tranches of the Theatre Review recommendations

- The full action plan is provided as appendix and details the recommendations for all of the tranches

- The embedding culture tranche has been reorganised to reflect the progress already made and provide assurance that will continue to run concurrently with all other tranches

- There remains operational pressure within the Surgical Clinical Board, Perioperative Care Directorate and Theatres Together Programme. Additional support is being provided to help mitigate

Appendices:

1)Theatres Together Improvement Plan

Recommendation:

Board is requested to **NOTE** the progress on the Theatre Together Programme.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
Putting People First		Providing Outstanding Quality	
Delivering in the Right Places		Acting for the Future	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term	x	Integration		Collaboration		Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

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Theatres Together Improvement Plan

Version History:

Date:	September 2025
Author:	Theatres Together Project Team
Project Exec / SRO:	Paul Bostock
Version No:	1.2
Status:	Issued
Approvals	Theatres Together Triumvirate

Foreword

The Theatres Together project is being delivered through a structured tranche-based methodology, endorsed by both the project board and leadership team. This approach divides the work into five distinct tranches— Embedding Culture, Foundation, High Impact, Progression, and Transition—each designed to enable focused delivery, iterative improvement, and sustainable change.

Currently, the Embedding Culture, Foundation, and High Impact, tranches are being run in parallel to accelerate early gains and embed cultural change from the outset. The Progression and Transition tranches have been prioritised for recommendations that are less urgent, have lower immediate impact, or are dependent on higher-priority actions. This sequencing ensures that dependencies are managed effectively, and that change is delivered in a logical and sustainable manner.

All 66 actions within the project have been systematically assessed, risk-rated and prioritised using a weighted scoring methodology, underpinned by five strategic drivers: staff engagement, patient safety, creating a place to feel proud, theatre efficiency, and effective leadership. Each recommendation was assigned to a tranche based on its overall score and any critical interdependencies. This structured approach ensures that strategic focus, risk mitigation and investment are directed toward areas where they will deliver the greatest impact and value.

Theatres Together is governed through a robust structure, including a dedicated Theatres Triumvirate, with additional support from the Shaping Change, People and Culture and ECOD teams. Strategic oversight is provided via fortnightly project board meetings, while weekly scrum meetings drive operational progress. Task and finish groups have been established to deliver specific recommendations, ensuring focused and accountable delivery.

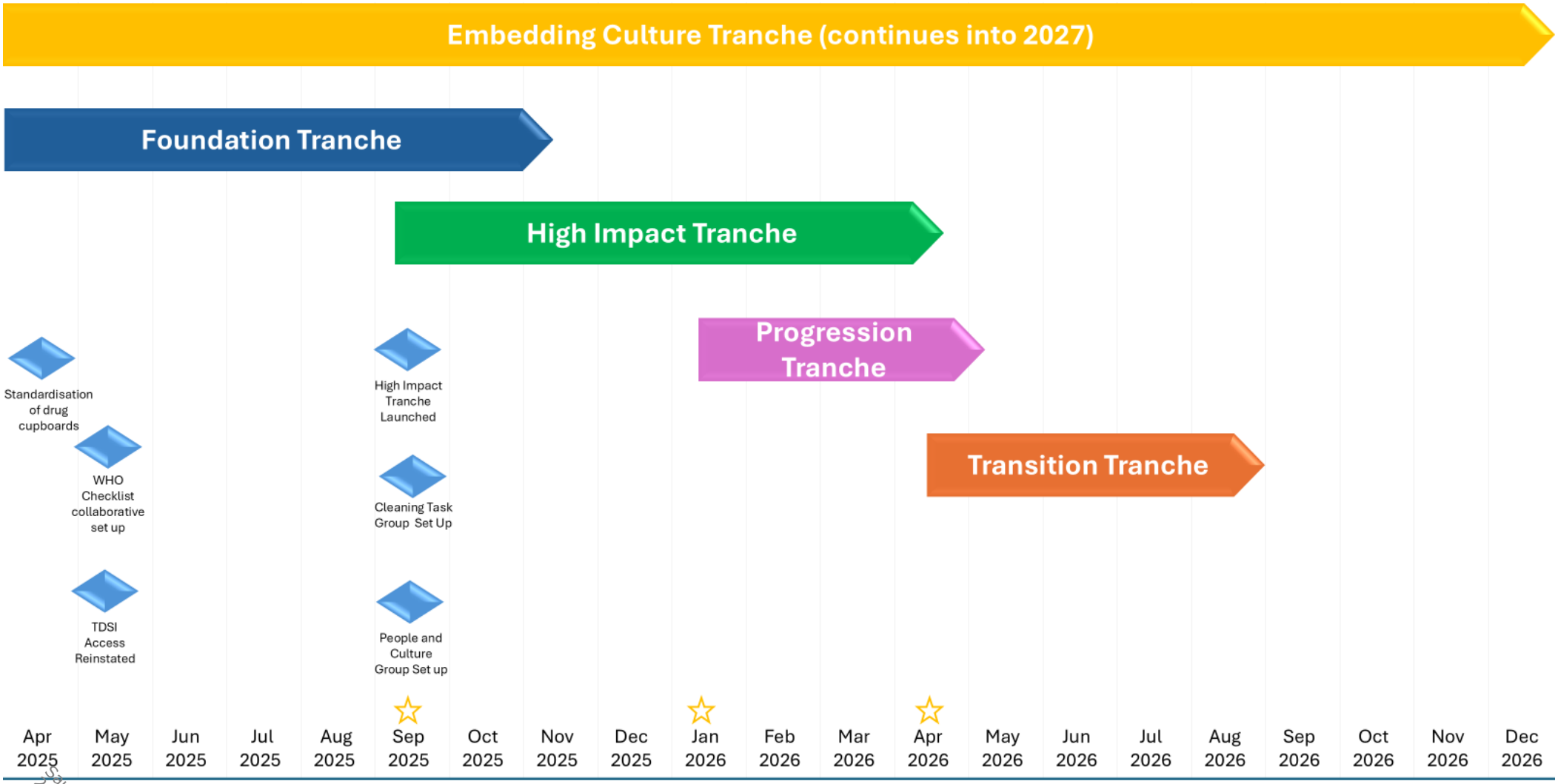
Each tranche concludes with a formal review to confirm delivery; capture lessons learned and ensure readiness for the next phase. While recommendations are initially allocated based on priority and dependencies, some recommendations may move between tranches as the project evolves. The Embedding Culture tranche runs continuously throughout the project, ensuring that values, behaviours, and leadership practices are integrated and sustained across all phases of change.

Theatres Together Project Update:

The Theatres Together delivery team has undertaken another comprehensive review of all recommendations to ensure each one is supported by a robust aim, clearly defined set of deliverables, and measurable outcomes. All risks and issues are identified and escalated appropriately within the governance framework described below.

As a result of this review, it has become evident that some recommendations would benefit from being brought forward into an earlier tranche to support more effective sequencing and delivery. This ongoing review process is essential to maintaining the stability of each tranche and ensuring that the implementation of recommendations follows a logical and sustainable path.

Theatres Together Timeline



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Theatres Together Governance Framework

Project Board Fortnightly

Function:

Strategic oversight and decision-making.

Members:

Senior Responsible Owner (SRO), Theatres Together Triumvirate, Delivery Team and Senior stakeholders.

Responsibilities:

- Review progress and risks.
- Approve major changes.
- Ensure alignment with strategic goals.
- Funding and resource decisions.

Weekly Scrum

Function :

Operational coordination and agile delivery.

Members:

Theatres Together Triumvirate, Delivery Team and subject matter experts.

Responsibilities:

- Tranche planning and delivery.
- Progress updates from subject matter experts.
- Issue resolution.
- Resource management.

Task and Finish Groups

Function:

Specialised delivery of recommendations within a tranche.

Members:

Subject matter experts, cross-functional team members.

Responsibilities:

- Delivery of recommendations within a tranche.
- Escalation of risks and issues.
- Problem/solving and decision making.
- Identification of benefits.

Tranche Checkpoint

Function:

Periodic review of progress across phases or tranches.

Members:

Representatives from all governance layers.

Responsibilities:

- Evaluate outcomes and lessons learned.
- Adjust plans for future tranches.
- Validate benefits realisation and stakeholder satisfaction.
- Closing/launching a tranche.

Embedding Culture Tranche

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
1a	Some individuals' values and behaviours need to be managed via UHB policies and procedures.	Everyone who needs to be part of a process is.	People & Culture.	Dependant on process timelines.	Fair, equitable and appropriate adherence to UHB policies and procedures. Staff compliance with the UHB Values and Behaviours.	Identified and actioned appropriate UHB policy and processes within a timely manner.	All necessary processes are underway to address current issues.
1d	Cultural action plan and programme of delivery to be developed by the Clinical Board with support from People and Culture including the Education, Culture and Organisational Development Team to improve the culture, trust, and psychological safety within the department.	Theatres is a place where people feel safe to work in an open trusted environment.	Theatres Together Delivery Team and People and Culture.	April 26	Improved culture, trust, and psychological safety within the department.	Conduct a Psychological safety survey.	Draft questionnaire has been developed, need to work through process of dissemination - expected date 30/09
						Share blended training materials -incivility, psychological safety etc.	Currently collating and analysing all training material. Need to agree how this will be shared with staff. Expected completion Oct 30
						Attend and deliver sessions during audit days.	Audit day dates are in the diaries, draft sessions development, to be agreed. (Monthly)
1f	Adherence to values and behaviours of the UHB and consequences for those that do not. Support for the team to feel safe and confident to challenge when values and behaviours are not in line with what is expected.	Adherence to the UHB values and behaviours.	Perioperative Directorate. People and Culture.	December 26	Values and behaviours discussed regularly and more formally as part of the VBA process.	Ensuring leaders have received VBA training. Review VBA compliance. V&B awareness sessions. VBA reviewer ratio analysis. Continue to promote speaking up safely.	VBA compliance report to be produced by end Sept. Audit session on 21 October to deliver V&B awareness.
2c	Offer a comprehensive leadership and management development program, along with a support package for the current leadership team in Mains Theatre Upper, to strengthen their ability to implement cultural and behavioural changes throughout the department. This will encompass leadership training focused on compassion.	Leaders have skills and confidence to create a safe, developmental, positive culture.	Theatres Together Delivery Team and People and Culture.	June 26	Leaders receive leadership training and support to deliver a measurable change.	Identify and enrol 8 individuals to attend the course. 8 individuals to undertake OD course funded by HEIW.	Individuals have been confirmed, and course will commence September 2025.
						Theatre Managers to attend Clinical leadership programme.	The course is being tailored for the cohort. This will commence Dec 2025 and will be a rolling programme.

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
					Process in place to identify on an ongoing basis leadership development programme.	Identify individuals to attend existing internal management courses e.g. essential management.	This will be part of the conversation about developing the training needs analysis action references recommendation 3c & 8m.
2f	Improved visibility of the Directorate and Clinical Board Management team within the department including attendance at audit sessions.	Directorate and Clinical Board Management teams are visible and accessible.	Perioperative Directorate and Clinical Board.	April 26	Visibility, confidence in leadership. Ability to speak up and creating a culture of bi-directional communication.	Clinical Board to conduct a variety of sessions to be more visible in the department e.g. walkarounds, audit sessions meet and greets. Develop a 6 Month proposal of sessions split across the SMT. Develop a 6 monthly rota for Perioperative directorate to be visible across theatres suites, implement agile working to promote visibility within the perioperative team - Rota to be developed.	Focus groups held in May and June which were well received. Further sessions to be planned with the Clinical Board.
2g	Ensure the effective utilisation of audit sessions by having meaningful activities planned for all team members who are scheduled to work. Attendance should be mandated.	Accessible, regular attendance at audit sessions for all theatre staff.	Educational Lead and Perioperative Directorate.	December 25	Improved staff engagement, access to education and learning opportunities. Increase staff attendance and improve internal communication.	Development of all day sessions. Effective rostering to ensure access to all staff. (Emergency theatre staff) Clear agenda for sessions. Clear feedback opportunities. Attendance is logged.	First all-day session is planned for 21st October.
2j	Explore collective leadership training. There is evidence to suggest that traditional hierarchical leadership model is clearly failing in healthcare. It is becoming increasingly evident that the interdependencies in healthcare require more collective leadership. To have a more inclusive approach to leadership, one that is typified by shared responsibility and accountability and a focus on collective impact rather than individual achievement.	This recommendation will be fulfilled by the deliverables outlined in recommendation 2c.					

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
3e part 1	**Review the Education Team structure and workload.** Work with HEIW and HEI to develop and commission Level 7 post graduate qualification for Perioperative Care Module to support the development of a multi-skilled theatre practitioner workforce. Benchmark with other units, such as University College London Hospital.	Have an effective education programme that meets the needs of the perioperative team.	People and Culture, ECOD and Theatre Together Delivery Team.	April 26	Evidence based programme that meets the need of the perioperative team.	Undertake a Training needs analysis of all perioperative staff. Training and educating the Education team so they can deliver the training requirements. Develop the education programme.	Training needs analysis session planned for 1 October. This recommendation is linked to 3c and 8m. The second part of the recommendation will be picked up later in the project.
4b	Review the role of the Education Team and develop clear purpose, and responsibilities to be communicated across the Directorate.	Have an effective education programme that meets the needs of the perioperative team.	People and Culture, ECOD and Theatre Together Delivery Team.	April 26	Appropriately resourced education team to deliver education programme.	Accessible comms around the role of education team Developing a role profile for the education team	This is dependent on the education programme actions - 3e
7a	Explore use of 'stay' conversations to help with retention and encourage the completion of exit questionnaires/ interviews.	Implementation of stay conversations and exit questionnaires to improve retention.	Perioperative Directorate.	April 2026	Staff leaving theatres complete exit questionnaire.	All questionnaires are currently under review. Ensure managers are encouraging staff to complete exit surveys.	
8g	Regular training should be carried out to ensure that all staff maintain skills and competencies. This needs to include night staff.	Staff receive training that is relevant to their role.	Perioperative Directorate. People and Culture	April 2026	Establishing a baseline for staff skills and competencies for the role.	Undertake an analysis of staff who require additional training. Review and refreshing existing training plans.	
8k	The cultural and leadership work will help to strengthen the team to feel safe and empowered to speak up and challenge where policies and procedures are not followed.	This will be addressed in delivery of recommendation 1f.					

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
9a	Review the start time of the theatre day and how staff are allocated. Ensure that all team members are responsible for patients arriving in the department on time. Consider using the recovery area in the morning for patients to wait before surgery. Consider if Theatre Assistants, Healthcare Support Workers, and Recovery Practitioners can assist in collecting patients from the wards.	All patients scheduled for theatre arrive on time and ready for surgery, reducing late starts more than 15 minutes to less than 20% (aligned with GIRFT standards).	Task and finish group and Perioperative Directorate.	March 2026	Reduction in late starts. Clarity and consistency across the workforce. Clarity on rhythm throughout session including team brief and de-brief.	Identify stakeholders. Set up task and finish group with appropriate governance and clear deliverables. Gather data including theatre observations.	Task and Finish Group has been established and held its initial meeting. Observational work within theatres is underway, with early findings highlighting areas of inefficiency.
9c	Identify consistent overruns and inefficiencies and review rosters to plan shifts for late finishes.	Reduce end of list delays and overruns by implementing improved staffing procedures.	Task and finish group and People and Culture.	December 2025	Reduction in avoidable overruns. Develop process to support staffing in the event of an unplanned overrun.	Identify consistent overruns. Identify avoidable overruns and plan for Establish the number of sessions per speciality. Establishing a consistent process for unplanned overruns.	Task and Finish Group has been established and held its initial meeting. Observational work within theatres is underway, with early findings highlighting areas of inefficiency.
9d	Conduct a review of theatre utilisation and compare it to pre-COVID levels. Identify the reasons for any differences, determine the expected downtime between cases, and establish a reasonable number of cases to include on a list in line with best practice standards for cases per session and GIRFT (Getting it Right First Time). Share this analysis with the team to ensure that expectations are clearly defined.	Aligning session utilisation with GIRFT standards and reducing avoidable downtime compared to pre-COVID benchmarks.	Task and finish group and speciality managers.	December 2025	Completed review with recommendations.	Establish baseline data and undertake initial analysis.	Analysis of initial data to compare with pre covid levels. Indication that late starts have increased but there is further analysis required. Task and finish group will be taking forward the review and outlining recommendations.

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
9f	Review the draft procedure for effective staffing resources and implement to help support the handover of patients to recovery practitioners to minimise delays at the end of lists	Patients move from theatre to recovery without delay.	Task and finish group and Perioperative Directorate.	December 2025	Review to understand requirement of recovery for theatre complex. Have appropriate physical infrastructure and staffing resources to deliver requirements.	Establish baseline data. Undertake theatre observations.	Task and finish group have been set up and have had the first meeting. Observations in theatres have started to identify inefficiencies.
9g	Clinical leaders to be involved in scheduling of lists to aid roster management. Explore how the publishing of rosters could align to the 6,4,2 process.	To have a robust scheduling system that enables properly resourced sessions.	Task and finish group and Perioperative Directorate.	December 2025	Clinical leaders attend 6-4-2 scheduling sessions for planned work. Adopting rostering principles - 6 weeks in advance.	Ensure clinical leaders attend all 6-4-2 meetings for planned. Providing education to clinical leaders for adopting rostering principles.	Clinical leaders in both UHW and UHL attend weekly 6-4-2 meetings. Improvement in rostering via Health roster introduction which has supported publishing of rosters.

Foundation Tranche

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update (all dates end of.)
1h	Explore security options to make the female changing area a more secure place to leave belongings.	To make Main Upper Theatres a safe and secure area for staff and patients.	Theatres Together Delivery Team.	October 25	Provide secure changing rooms with lockable storage for all staff.	Additional TSDI for the female and male changing room, and the scrub room. Undertake an audit of the locker rooms to confirm that every person has been offered access to a locker and ensure access for all staff.	Additional TDSI equipment has been ordered – October 25. Audit Complete, all Theatres staff have access to a locker.
					Development of a UHB Theatres Visitors Policy.	Update the existing policy. Sign off policy following UHB governance processes. Implement Policy.	The Procedure for the Management of Visitors within the Operating Environment exists and a UHB Theatres visitors policy has been developed. Policy is being presented at the Perioperative Directorate Quality and Safety Meeting. The policy will be shared with Corporate Governance to take through the UHB ratification process.
					Secure theatres.	Reinstate/repair existing TDSI access to the main department. Temporary TDSI passes will be provided to visitors following completion of TDSI installation. Cleanse current access list.	Complete. TDSI Installation – October 25. September 25.
5g	Provide colleagues with the necessary clinical information about patients that is pertinent to their role for maintaining safety of both staff and patients.	All staff involved in with the transportation of the patient to and from theatre get the pertinent information at appropriate points to ensure safety of patients and staff.	Surgical Clinical Board and Lead Nurse.	December 2025	Develop a systems approach to ensure the communication of pertinent information to relevant staff.	Include pertinent information about patients, including infection control information. Co-produce the system with all relevant stakeholders.	Initiating co-production with portering service to define roles, responsibilities, and channels of communication.

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update (all dates end of.)
8a	Audit adherence to policies and procedures for consent and 'WHO Checklist,' ensure standardised application across all theatres and provide update training as required.	Routine effective use by all staff of 5 steps of surgical safety in all procedure areas.	Surgical Clinical Board and Lead Nurse	March 26	In partnership with the Perioperative team and surgeons develop a set of principles that must be adhered to, that support a standardised WHO checklist process.	Establish a multi- professional WHO Checklist collaborative to design a programme of improvements to support compliance with the WHO checklist. The WHO Collaborative reviewed the outcomes from patient safety incidents associated with non-adherence with the WHO checklist and co -produced a set of principles that standardised the checklist process and adherence with the checklist.	Communication from the Clinical Executive Team was sent to all Perioperative workforce and all surgeons on 13 May 2025 mandating the principles:
					Deliver the required systems and processes to ensure 100% adherence with the WHO checklist and to provide the correct resources to support adherence.	Engagement events have taken place to embed the WHO checklist principles. Co-produce the design principles for a WHO Checklist	In partnership with the Perioperative team, anaesthetists, and surgeons the WHO collaborative has developed a set of principles that must be adhered to, that support a standardised WHO checklist process. We have developed the required systems and processes to ensure adherence with the WHO checklist and to provide the correct resources to support adherence. We have verbalised the expectations as widely as possible across the Health Board across as many staff groups as possible Scoped possibility of Perioperative white board to visualise the WHO checklist Carried out baseline audit of compliance with required systems and processes Co-production of the design principles for a WHO Checklist Whiteboard is complete, and the draft design is to be presented at WHO collaborative.

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update (all dates end of.)
					Deliver systems to ensure completion of consent prior to transfer to theatre.	Define processes and expectations for completion of consent Concentric E Consent Platform to be piloted in Ophthalmology and Cardiology.	Communications have been shared to remind all staff of the requirement to ensure pre-operative checks are completed prior to the patient leaving the ward, including checking the presence of a consent form. Theatre assistants have been informed that patients must not leave the ward without a signed consent form. In the event that a consent form has not been completed they must escalate to the theatre manager.
					Deliver strengthened digital record of theatre activity.	Replacement of Theatreman.	Introduction of Aqua theatre system as a replacement for Theatreman with associated SOP, training, and audit of the system. Testing to commence in September 2025.
8b	Examine the management of paediatric cases operated on in Mains Upper and determine whether the current arrangement of recovery in the adult recovery area aligns with the Royal College of Anaesthetists' Guidelines (Chapter 10: Guidelines for Provision of Paediatric Anaesthesia Services 2025). Assess the measures taken to safely manage children. Investigate what is required to fully utilise Children's Hospital for Wales to ensure that paediatric cases are operated on and recovered within Children's Hospital for Wales.	Compliance with RCA recommendation where possible.	Theatres Anaesthetic Leads.	October 25	Standardised provision of Paediatric Anaesthesia services in line with Royal College of Paediatric Anaesthesia Guidelines.	Undertake a Gap analysis of paediatric care against the Royal College of Anaesthetists Guidelines Chapter 10 Guideline of the Provision of paediatric Anaesthesia Services 2025. -Agree model for the delivery of paediatric surgery in main theatres that includes required education and skills and staffing requirements.	A review of the paediatric recovery bays undertaken in partnership with Children's Hospital of Wales to ensure that these areas meet the needs of paediatric patients and their families. All required equipment has been identified, and funding support is being sought from Noah's Ark Charity.

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update (all dates end of.)
8e	Create standard operating procedures for the setup and standardisation of anaesthetic rooms throughout the department, where feasible.	Improve patient safety by decreasing variation in processes for ODP in main uppers.	Theatres Anaesthetic Leads.	December 25	Standardisation of the anaesthetic room layout and design.	Design and co-produce a standardised anaesthetic room with Perioperative workforce.	Standardised contents list for drug cupboards has been produced with Anaesthetists and Anaesthetic Practitioners. -Standardised list of consumables and non-consumables Theatre ownership plan has been developed ensuring rotation of staff provides exposure and experience within different specialties A review of required equipment has been undertaken. Equipment quotation requests have been submitted for storage trollies to replace cupboards. Costings developed for environmental improvements and submitted to UHB Senior Leadership Team Meeting. Agreed at Senior Leadership team and to progress for discussion at Capital Management Group.
					Implement anaesthetic emergency toolboxes.	Co-produce with anaesthetics to identify equipment and implement toolboxes.	Anaesthetic emergency toolboxes are in Theatre 1, Theatre 10, and Recovery, containing emergency drugs and guidelines for anaesthetic emergencies.

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update (all dates end of.)
8h	Standard Operating Procedures and schedules for the theatre deep cleaning rota, including weekend protocols that are standardised across all theatre suites	Ensure all theatres are cleaned following UHB procedure and standard for theatre	Theatres Together Delivery Team.	October 25	Implement Standardised cleaning processes that meet the standards set out in the Perioperative Theatres Cleaning Procedure and national standards.	Cost established for cleaning schedule, initial deep clean and one-off HPV clean - submitted to Senior Leadership Team. Further discussion to explore the resourcing of standardised cleaning of theatres across the UHB. Review of the operational arrangements for cleaning main theatres to align with other theatre areas within the UHB. Develop a cleaning schedule checklist for each for individual theatre and communal areas.	Theatres Cleaning procedure has been reissued to all staff. Workshop to be run to identify current approaches and variation across theatre areas. September 25. Task and finish group established.
					Align cleaning policy with updated CNO All Wales Cleaning policy when this is published.	Undertake a gap analysis of cleaning procedures against CNO All Wales Cleaning policy when published.	Not yet published.
8i	The family room requires refurbishment. Explore options for charitable funding to improve the environment for relatives waiting. This space could also be used for staff to pray or take some quiet time when not in use.	Refurbishment of family room (John Davies room).	Theatres Together Delivery Team.	October 2025	Refurbishment of family room.	Develop refurbishment plan for family room. In conjunction with Capital, Estates and Facilities.	Awaiting confirmation work timescales.

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update (all dates end of.)
8j	Charitable bid to the Staff Lottery Fund to refurbish the staff room, including new furniture, fridges, and a dishwasher.	Provide a comfortable space for staff to rest in main uppers.	Theatres Together Delivery Team.	October 2025	Refurbishment of the Perioperative Staff Room.	Design of the Staff room co-produced with Perioperative workforce. Bid to Charitable Funds Committee for staff room refurbishment agreed on 10 June 2025. Identification of an interim staff room during the refurbishment period alternative staff room. Refurbishment work is planned for September 2025.	Refurbishment work will start on Monday 8th September and is expected to take 2 -3 weeks.
9e	Explore how all theatres can work collaboratively to support efficiency including how Children Hospital for Wales is staffed on weekends and bank holidays.	Understand if there is benefit of staff movement across theatre suites	Task and finish group and Perioperative Directorate.	October 2025	Recommendation for next steps if needed	Review activity and staffing model in children's hospital on weekends.	

High Impact Tranche

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
1b	Share the HSCW code of conduct to support individuals to be aware of the code.	All HCSW are aware of the code of conduct.	Theatres Together Delivery Team and People and Culture.	December 25	Ensure that the HCSW Code of Conduct is used to support professional conversations.	Re-distribute code of conduct to HCSW staff A review of the Values Based Appraisal process will ensure that the code of conduct is integral to the appraisals of Health Care Support Workers.	Code of conduct has been re-distributed to HCSW staff.
1c	To Share with colleagues how to raise concerns internally, share 'Speaking Up Safely'. Consider support from HCPC and NMC on culture, the code and when to report to the regulator.	All staff feel able to speak up safely and raise concerns through appropriate channels	Surgical Clinical Board Lead Nurse	October 25	Promote the use of 'Speaking up Safely' to staff.	Speaking up safely highlighted to all staff via communication from the Chief Executive following the publication of the theatre review. UHB Leaders who Listen engagement framework will promote awareness of the 'speaking up safely' process. Speaking up Safely is being promoted as part of all staff surveys and the UHB-wide screensavers. Staff side representative has held safe space session in main theatres for staff that work in upper main theatres.	
					Consider support from HCPC and NMC on culture, the code and when to report to the regulator.	Contact the regulatory bodies to access advice on reporting to a regulator and consider how this information is shared.	
1e	Consider support from a psychologist on a substantive basis to support colleagues through trauma informed approach in a similar way to that of critical care and major trauma. Further roll out of MEDTRIM	Staff have appropriate access to psychological support.	Theatres Together Delivery Team.			Review recommendation with Clinical directorate	Focus on MEDTRIM roll out and its impact before further understanding resources already available to staff via canopi and employee wellbeing services.

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
1g	Celebrate success - feedback to the team when they receive positive feedback.	All staff feel recognised for their achievements.	Theatres Together Delivery Team and Leadership Team	October 25	Implement a range of initiatives to celebrate success and provide feedback.	Share positive feedback with the team promptly and visibly. Use team meetings or internal channels to celebrate success. Recognise individual and collective contributions. Encourage a culture of appreciation and alignment with values	A range of initiatives have been implemented across all four Perioperative areas to promote staff engagement, recognition, and wellbeing. These include: Shout-out boards have been introduced to showcase staff feedback and Greatix submissions. Student feedback is regularly shared via notice boards and social media platforms such as Facebook. Positive feedback/ team successes are communicated through WhatsApp groups. Greatix process has been widely promoted to encourage staff participation. Newsletters are used to highlight good practice and achievements, and wellbeing events, including celebrations for Nurses, ODPs, and HCSW as well as events including bake sales, quizzes etc. Surgery Star Awards is an opportunity to recognise individuals and teams for their efforts. Staff are encouraged to engage with updates and discussions via Viva Engage. Star of the month process has been positively received within Anaesthetic Practitioners and discussions are underway to expand this to teams of the month. Communications about the re-runs of the Saving Lives in Cardiff TV programme has been broadened to reflect the contribution of the wider perioperative team as well as the surgeons. Collaborate with the communications team to agree further opportunities to celebrate success aligned to maternity communication.

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
1i	Investigate measures to ensure sufficient availability of scrubs for staff who require them, preventing access by colleagues not assigned to the theatre environment.	Ensure appropriate access to scrubs for all theatre staff and reduce unnecessary financial waste.	Theatres Together Delivery Team.	December 25	Appropriate staff will all have the scrubs they need	TDSI access for theatre staff Develop clear process and guidance for scrubs Investigate feasibility of scrub machine	Putting TDSI on door in October.
2h	Sickness panels supported by People and Culture colleagues, to be conducted to ensure consistent approach, with regular attendance by clinical leads or deputies.	There is a consistent and effective approach to managing sickness.	Theatres Together Delivery Team and People and Culture.	October 25	Strengthen sickness management with support from people and Culture	People Services to meet with Theatre Managers on a weekly basis to review the previous weeks sickness cases to support with management of cases. Sickness absence training/support to Clinical Leaders. Sickness management forms part of the monthly Executive Reviews.	Regular sickness panels have been established with Theatre Managers, Lead Nurse, DON and Senior People and Culture Business Partner.
2i	A senior advisor from people services should be allocated to theatres to provide consistent advice for the leadership team.	A senior advisor is available until the point all are comfortable in ability to manage situations with usual resources.	Theatres Together Delivery Team and People and Culture.	September 25	Appoint senior advisor from Peoples Services to support theatres.		A senior PS advisor has been appointed to support theatres as part of Surgery Clinical Boad.
3b	Review of the workload of the clinical leaders to assess the feasibility of making them supervisory in line with their ward-based colleagues. Share with the team what is expected of the Clinical Leaders in their non-clinical time.	To have effective clinical leaders working in line with a standardised approach.	Theatres Together Delivery Team	October 25	Explore the feasibility of a supervisory clinical leaders' team with clear guidance developed to ensure responsibilities articulated.	A review of staffing establishment will be undertaken to identify resource requirements to support clinical leaders in a fully supervisory role. Develop guidance for clinical leaders to support a standardised approach to their supervisory duties. Gap analysis of all clinical leader's non-clinical time.	This action cannot be completed in isolation as it forms part of the workforce planning process. Initial meeting to begin scoping a Theatres Workforce plan will be held on 12th September 2025.
3c	Clearly defined roles and responsibilities and ensure accountability for fulfilling them across the workforce. Consider developing a training needs analysis to support the development of staff.	Have an active and visible workforce plan and structure.	Theatres Together Delivery Team and People and Culture.	April 26	Develop a workforce structure with clear lines of reporting and responsibility.	A review of Perioperative workforce structures, roles and responsibilities will be undertaken to clearly define with line management and reporting/escalation arrangements. A large-scale review of all education for all non-medical staff within the Perioperative Directorate will be undertaken to inform an educational strategy and a training needs analysis. That will expand access to leadership, clinical, and Level 7 education programmes and resources delivered internally to the UHB as well as national programmes of education (8m (part 1)).	Initial meeting to begin scoping a Theatres Workforce plan will be held on 12th September 2025.
5a	Implement regular team meetings for all staff to improve communication and engagement.	Have clear and effective flow of information across all staff and set expectations of meeting structures and outcomes.	Theatres Together Delivery Team.	October 25	Develop a department meeting structure to ensure engagement with all staff.	Set Clear expectations for engagement and meeting with teams Establish Regular Band 7 Forums Clinical Leaders need supporting to meet regularly with their respective teams. Forums for all staff groups to be planned. Protect Q&S Sessions and changed to all day sessions with rotas arranged to ensure	-Clear expectations for engagement and meeting with teams have been set by the Theatres Management Team. Regular band 7 forums have been established. Clinical Leaders are supported to meet regularly with their respective teams. Forums for all staff groups are currently

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
						staff have opportunities to attend. Establish a Directorate Management Team (DMT) to provide a structured weekly forum for departments to share staffing updates, operational issues, and key information, promoting consistent communication across the Directorate.	being planned. Q&S Sessions are protected and have been changed to all day sessions with rotas arranged to ensure staff have opportunities to attend. A Directorate Management Team (DMT) has been established to provide a structured weekly forum for departments to share staffing updates, operational issues, and key information, promoting consistent communication across the Directorate.
5b	Consider reinstating the General Manager /Lead Nurse drop-in sessions on a regular basis.		Theatres Together Delivery Team.	October 2025	General Manager / Lead Nurse drop-in sessions will be reinstated monthly from October 2025.	Meetings to be scheduled until Q1 2026. Dates and time of meeting will be shared via all communication channels.	Meeting with the Theatres Admin to co -ordinate meetings.
5c	Regular meetings with General Manager, Lead Nurse, and Theatre Manager with set agenda.		Theatres Together Delivery Team.	October 2025	Regular two to one meeting between the General Manager Lead Nurse and Theatre Manager have been re-established.	As above. Agenda to be agreed and terms of reference.	As above.
5d	Regular meetings with General Manager, Lead Nurse, Theatre Manager and the Clinical Leaders.		Theatres Together Delivery Team.	October 25	A programme of meetings between the General Manager, Lead Nurse and Theatre Manager and the Clinical Leads is being developed.	As above. Agenda to be agreed and terms of reference.	As above.
5e	Consider implementing the use of team briefs across the entire suite to enhance teamwork. This approach could be beneficial in celebrating successes, addressing concerns such as the impact of staff sickness in specific areas, and checking in with staff, particularly following challenging cases.	Have clear and effective flow of information across all staff and set expectations of meeting structures and outcomes.	Theatres Together Delivery Team and People and Culture.	October 25	Implementation of team briefs	Undertake an exercise to map out pathways for support for theatres. MedTrim response was implemented in June 2025. Twenty-three members of staff have undertaken MedTrim training with further training planned. MedTrim response is supported with a protocol to standardise the implementation of de brief. Roll out has been supported by awareness raising session.	
5f	Verify who has UHB email accounts and ensure that all individuals have access. Consider alternative methods of mass communication, such as Theatres SharePoint Site, Viva Engage or Teams Channels, instead of relying Soley on WhatsApp.	All staff have access to an email account.	Theatres Together Delivery Team.	September 25	Provision of emails accounts to all staff.	Identify numbers of people who have signed up to viva engage. Communications will be sent to all staff without email addresses with their login details. Communication will include promoting the benefit to staff of accessing their email account, including improved communication within the department and the potential additional benefits to the individual staff members, such as access to NHS discount schemes.	An audit has identified that 25% of theatre staff did not have an activated email account. A department meeting structure has been developed (action 5a) to ensure engagement with all staff. Education team working on Padlet page.
6a	Conduct a comprehensive review of rostering practices, including an analysis of shift times and their correlation with late finishes, late starts, and early finishes. Specifically, assess the feasibility of	Staffing levels match theatre delivery requirement.	Theatres Together Delivery Team.	September 25	Undertake a review of rostering practices to identify areas for improvement.	Undertake systematic review of current health rostering, to include: Sign-off dates. Requesting process. Annual leave. Health rostering learning sessions to be conducted in collaboration with the Health Rostering Team and the Corporate Nursing	Health rostering learning sessions have been conducted in collaboration with the Health Rostering Team and the Corporate Nursing Team to support improvements in workforce planning. Existing roster templates are currently under review, with a focus on aligning

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
	implementing 12-hour shifts within the Recovery teams.					Team to support improvements in workforce planning. Review existing roster templates, with a focus on aligning list start and finish times with staff working hours.	list start and finish times with staff working hours.
					Scope the feasibility of implementing 12-hour shifts.	Plan a trial of 12-hour shift patterns to explore potential benefits for service delivery and staff wellbeing. Review the numbers against the establishment spreadsheet to see how this would work. Once completed the outcome of the pilot will be presented at the Nursing productivity Group. Communicate principle that 80% of AL is to be booked by December 2025 for 2026/27 as per UHB rostering policy.	A draft of the 4-week roster has been prepared, providing a clearer view of how the arrangement would function in practice.
6b	Promote a culture that supports colleagues in managing their work-life balance. Review all current work-life balance requests in accordance with the needs of the service to ensure appropriate coverage on all shifts.	Embedding an equitable work-life balance application process.	Perioperative Directorate Team.		There is equity across theatres in the application process.	Promote flexible working awareness and training to staff and managers. Share policy and procedure with staff including relevant documentation and appeal processes.	This recommendation will also link to 2d/2e that looks at clinical leader's competencies/capabilities to ensure these HR processes are also included. This would be picked up with ongoing collaboration with people of OD.
8f	Consider wider use and implementation of 'Tendable' to monitor compliance against standards and procedures including use of PPE. This would give more oversight to the Directorate and Clinical Board. IPC colleagues.	All clinical leaders and deputies have access to tendable and there is an audit schedule set up.	Theatres Lead Nurse	September 25	A programme of Infection prevention and control quality assurance will be developed with clear reporting and exception reporting arrangements.	Perioperative directorate will develop a timetable of IP&C audits to be undertaken by Clinical Leaders. These audits will be presented at the Perioperative quality and safety and reported by exception at the Surgery Clinical Board Quality and Safety Forums and the UHB IP&C meetings.	
8m (part 1)	**Review training on offer for new starters is the course transferable and does it cater for all learners.** Explore working with HEI's and HEIW on commissioning a post graduate level 7 perioperative care module.	New starters are supported and mentored to be competent and confident in their roles.	Theatres Together Delivery Team and People and Culture	September 25	Develop a Perioperative Education strategy that supports succession planning.	Meet with the University College London to explore their Theatre Workforce Strategy. A large-scale review of all education for all non-medical staff within the Perioperative Directorate will be undertaken to inform an educational strategy and a training needs analysis. That will expand access to leadership, clinical, and Level 7 education programmes and resources delivered internally to the UHB as well as national programmes of education.	

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
					Development of a new starters' education programme for all professional groups.	Review new starter education Identify a funding source for resuscitation training for ODP.	Review of new starter education programme has been undertaken, and education and competency booklets have been further developed to support this approach. Work has been undertaken with HEIW to agree funded places for leadership and organisational development, cardiothoracic study days and Facilitated teaching and learning education.
9h	Review provision and access to computer and printers across the suite to support efficient working.	Staff are given dedicated resource and time to support efficient working.	Theatres Together Delivery Team.	April 2026	Staff have access to computers in theatre suites.	Provide cost for additional equipment and instillation.	This aligns with giving staff email for access as well as opportunities to do training and access to comms.

Progression Tranche

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
2b	Conduct a comprehensive review of the Directorate and departmental leadership and management structure, including the Clinical Lead workforce and the Education Team, to ensure clarity in roles and responsibilities within the management team. Benchmark with equivalent sized services.	Conduct a comprehensive review of the structure to ensure there is clarity of roles throughout.	Theatres Together Delivery Team and People and Culture.	April 2026	Completed review, clarification of roles and responsibilities.		Meeting on 12th September with People and Culture and Theatre Delivery team to scope/agree deliverables.
2d	Review expectations and competencies for the clinical leaders, set clear expectations of the role and support them to manage. Identify areas where there may be capability issues and implement targeted programs to address these gaps	Clearly defined clinical leadership roles and address capability gaps through targeted development programmes.	Theatres Together Delivery Team and People and Culture.	April 2026	Delivering a band 7 competency for clinical leaders throughout theatre suite.		This will form part of the workforce delivery plan.
2e	Define the expectations for Clinical Leads regarding the allocation of time between clinical and non-clinical duties. Investigate how supervisory status could be structured and the appropriate use of this time, such as participating in 'intentional rounding,' providing team support, teaching, management of clinical incidents including DATIX, ensuring breaks are taken, and performing audits using the 'Tendable' platform	Define appropriate allocation of time between clinical and non-clinical duties.	Theatres Together Delivery Team and People and Culture.	April 2026	Undertake a skills analysis for current Clinical Leaders. Succession planning for induction of new Clinical Leaders.		Dependent on the outcome of 2d. When there is clarity on the role, responsibilities, and expectations of a clinical leader (2d) this will feed into the ability to understand appropriate allocation and expectations during non-clinical duties.
3a	Appoint substantively to provide stability in team.	Appoint substantively to meet full establishment.	Perioperative Directorate Team.	April 2026	Review current position and where appropriate make appointments substantively.	Identify vacancies and fixed term contracts. Advertise as per CVSP.	Theatre Manager substantively appointed.

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
3d	Ensure the competency framework for clinical leaders is current and accurately reflects the requirements of the role, providing a clear pathway for their development.	This is linked to 2d and 2e.		April 2026			Will flow from the deliverables of the workforce plan.
4a	Support the Clinical Leaders work collaboratively to ensure the safe operation of the department, under the supervision of Mains Theatre Upper Theatre Manager.	This is linked to 2d and 2e.		April 2026			
4d	Review how the theatre manager/ coordinator role is covered at weekends and whether this should be a role that is supervisory.	To have safe and appropriate leadership cover over weekends.	Theatres Together Delivery Team and People and Culture.	April 2026	Identify appropriate staffing levels including supervisory time at weekends.		Meeting on Friday 12th September with People and Culture to identify any financial implications associated with this and explore feasibility.
6c	Review process for how ODP's can access Advance Practice Training in line with Nurses, AHPs and Health Scientists to support development and training.	Ensure ODPs have equitable access to support with their development and training.	Theatres Together Delivery Team and People and Culture.	April 2026	Clear process for ODP access to training.	Explore and communicate funding availability and process for application of funding for ODP. Highlight ODPs who require training.	One ODP who had been nominated over the last year has received funding and training.
6e	Review how the anaesthetic practitioner workforce supports the resus team, and major trauma calls and what skill set is required to support.	Clarity on role of anaesthetic practitioner's support resus team and major trauma calls.	Theatres Together Delivery Team.	April 2026	Review rostering principles of MERIT.	Workshop to look at roles / responsibilities / team working	This will form part of the workforce delivery plan.
7b (part 1)	**Assess the training and induction processes for Operating Department Practitioners (ODP).** Identify how training can be effectively utilised to ensure proficiency in multiple roles, such as scrub and anaesthetic positions. Conduct benchmarking against other centres to gain insights into the practical application of dual roles.	To understand the feasibility and benefit of having dual roles.	Theatres Together Delivery Team and ECOD.	April 2026	An assessment on feasibility of dual role.	Assess current induction process and identify potential areas for improvement.	This will form part of the workforce delivery plan.

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
7c	Protect study days and audit sessions.	Staff have study days and attend audit sessions.	Perioperative Directorate Team.	April 2026	Study days to be given to staff for education pertinent to their roles and time to attend audit sessions.	Share guidance on CPD hours with staff and study leave guidelines.	Staff are allocated study leave for essential education. Further study leave is applied as per UHB policy and guidelines.
8c	Conduct an equipment stock take and set up a replacement program with support from Clinical Engineering. Strengthen and develop the role of the Medical Devices Safety Officer within the Directorate.	Strengthen the relationship between theatres and clinical engineering.	Theatres Together Delivery Team.	April 2026	Conduct a stock take. Set up replacement program. Develop role of medical devices safety officer.	Set up a task and finish group to define deliverables of this recommendation including stakeholders from theatres, clinical engineering, IP&C, and other relevant teams.	The task and finish group will be set up towards January 2026.

Transition Tranche

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
1j	Focused programme of work to address the culture in Cardiac Theatres and develop leadership capacity and capability required to tackle poor behaviours.	Improve culture in cardiac theatres.	Theatres Together Delivery Team and Specialist Services.	August 2026	Work collaboratively with specialist services to ensure appropriate leadership and capability.	Meet with specialist team.	Work underway in Specialist Services to address issues identified.
2a	Radical restructure of the practitioner role across the department and the wider Directorate to provide flexibility across the suite and have a multi-skilled workforce to provide a sustainable and resilient service. Similar to the work undertaken by University College London Hospital.	To have a flexible workforce appropriate to meet the needs of the services.	Theatres Together Delivery Team.	August 2026	A workforce plan that meets the needs of the future.	To understand current workforce. To visit UCLH to understand the scope of their workforce plan.	This will form part of the workforce plan considerations.
4c	Evaluate the balance between flexibility across the suite and the advantages of having a discreet team. Consider a comprehensive re-evaluation of the roles and functions of scrub, anaesthetics, and recovery teams. Additionally, explore the potential for leveraging the skills from across Cardiothoracic Service to support cardiac theatres.	This recommendation links significantly with 2a. Completion of 4c will support with achieving deliverable outcomes in 2a.					
6d	Review the roles of the Band 2 and Band 3 Theatre Assistants, clearly distinguishing between them. Identify opportunities for Band 2 development within the department.	This is part of an all-Wales changed and actions will be picked up as part of this.					

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
7b (part 2)	Assess the training and induction processes for Operating Department Practitioners (ODP). **Identify how training can be effectively utilised to ensure proficiency in multiple roles, such as scrub and anaesthetic positions. Conduct benchmarking against other centres to gain insights into the practical application of dual roles.**	To understand best practice from other centres	Theatres Together Delivery Team and ECOD.	August 2026	Robust benchmarking data.	Arrange visit.	Initial conversations between centres have taken place.
7d	Compare the roles and responsibilities and number of band 6 roles in other organisations of similar size and complexity and share the findings with the team.	To understand workforce in other comparable size centres.	Theatres Together Delivery Team.	August 2026	Robust benchmarking data.	Arrange visit.	Initial conversations between centres have taken place.
8d	Clinical Directors of each Surgical Specialty to collaborate with Theatres to standardise surgical equipment and devices where feasible and safe. With assistance from procurement, establish minimum and maximum stock levels to ensure essential items are always available, use 'Scan for Safety' to manage stock efficiently and maintain traceability of consumables.	Appropriate equipment is available when needed.	Theatres Together Delivery Team.	August 2026	To standardise and reduce variation in surgical equipment and devices.	Set up task and finish group to look at procurement and stock management.	
8l	Review the IT systems in use across the theatre pathway and assess if they are fit for purpose, explore what it would take to get one system used by all to avoid duplication.	There is a development to existing theatre system theatre man, implemented in the new year so an immediate review would not be representative of the future state. An SBAR will be written to outline review of IT systems with note of feasibility challenges to introduce one system.					

Rec.	Recommendation	Aim	Owner	Expected Completion. end of:	Deliverable Outcomes	Key Actions	Update
8m (part 2)	Review training on offer for new starters is the course transferable and does it cater for all learners. **Explore working with HEI's and HEIW on commissioning a post graduate level 7 perioperative care module.**	New starters are supported and mentored to be competent and confident in their roles.	Theatres Together Delivery Team and People and Culture.	August 2026	A collaborative and agreed plan between CAVUHB and HEI/HEIW.		Discussions underway as part of other recommendations.
9b	Review reinstating the dual role of porter / HCSW.	To have a flexible workforce appropriate to meet the needs of the services.	Theatres Together Delivery Team and People and Culture.	August 2026	Create SBAR/recommendation document as output of review.	Include this at a later stage of workforce review.	

CARDIFF & VALE UHB
INTEGRATED PERFORMANCE REPORT COVER PAPER – September 2025


Finance
Public Health
Operational
Quality, Safety & Experience
People and Culture
Digital
Capital
Conclusion
Saunders,Nathan 21/05/2025 15:54:16

The UHB's Financial Plan in 2025/26 reflected the following key components:

Planning Assumptions	(£m)
Brought Forward Underlying Deficit	59.900
2025/26 Demand/Cost Growth/Improvement	51.100
Draft Deficit	**111.000**
Additional Allocations	(22.768)
Savings Plans	(32.000)
Initial Planned Deficit	**56.233**

The initial planned deficit of £58.2m was noted by the UHB for submission to Welsh Government (WG) and the draft plan was submitted at the end of March 2025. Welsh Government asked the UHB to detail further actions to reduce the forecast deficit of £58.2m. In response, the UHB confirmed that progress in the identification of savings provided sufficient assurance to increase planned savings delivery by £2m and reduce the forecast 2025/26 deficit position to £56.2m.

The submitted plan projects a deficit for the financial year and therefore a failure of the UHB's statutory requirement to deliver a balanced financial plan over a 3-year rolling period. This also prevents Ministerial approval of the plan.

At Month 5, the UHB is reporting a year to date overspend of £27.809m.

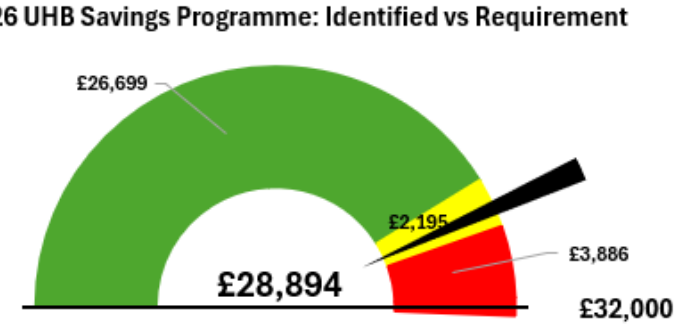
	Plan PTD (£m)	PTD (£m)	PTD Variance to Plan (£m)	Plan YTD (£m)	YTD (£m)	YTD Variance to Plan (£m)	Plan	Forecast	Forecast Variance to Plan (£m)
Draft Plan	7,179	7,179	0	35,017	35,017	0	88,233	88,233	0
Quality Efficiency Improvement Plans - Savings	(2,491)	(2,528)	(37)	(11,587)	(10,121)	1,466	(32,000)	(28,482)	3,106
Operational Variance	0	1,987	1,987	0	2,913	2,913	0	0	0
Clinical/Service Board Variance	**4,688**	**6,638**	**1,950**	**23,430**	**27,809**	**4,379**	**56,233**	**59,751**	**3,106**

The overall £27.809m deficit at month 5 was made up as follows:

- Planning Deficit **£23.430m**
- Savings Programme deficit of **£1.466m**
- Operational Position deficit **£2.913m.**

At month 5, there was a shortfall of £3.106m against the revised £32.0m savings programme target. This will lead to a further £3.106m overspend against the planned £56.2m deficit if further schemes are not identified and delivered.

At Month 05, the UHB had identified £28.894m (90.2%) of green and amber savings to deliver against the revised £32.0m savings target. Red schemes of £3.886m are also identified and continue to be reviewed for progression to Green/Amber where possible.



The reported in year gap of £3.106m in identified savings incorporates red schemes and the unidentified balance. The recurrent gap was higher at £8.480m . If further recurrent savings are not identified and delivered following month 5 there is a risk of further deterioration to the UHB's underlying deficit as illustrated below:

Planning Assumption	£m
Underlying Deficit (ULD) brought forward	59.900
Demand and cost growth and unavoidable investments	51.100
Quality Improvement Programme - savings	(32.000)
Additional Recurrent Allocations	(22.767)
Planned Underlying Deficit (ULD) at end of 2025/26	56.233
Shortfall against Recurrent Savings Target at month 5	8.480
Forecast Underlying Deficit (ULD) at end of 2025/26 without further identification of Savings & Actions	64.713

Further recurrent schemes are being developed to close the gap.

Obesity and Diabetes

- Vale of Glamorgan Council is set to become the **first local authority in Wales to restrict the advertising of unhealthy foods** in their spaces (bus stops /boards on the highway system). A recommendation report will be considered by Cabinet in September.
- A working group has been established to drive the equitable improvement in **diabetes 8 care processes** completion. This group is chaired by the primary care lead for diabetes and has membership from across clusters in CVUHB. The group has undertaken a **baseline assessment of available data** and has identified initial actions around sharing best practice and undertaking a more detailed assessment in clusters who have made significant improvements in uptake in the last 6 months.
- The principle of delivering the **All Wales Diabetes Prevention Programme across all 9 clusters** has been discussed and endorsed by Strategic Leadership Team. A comprehensive business case will continue to be developed in partnership between public health, primary care and dietetics (lead service), with input from Public Health Wales as this is a national programme.
- A **Board development 'deep dive' session** was undertaken late August, using type 2 diabetes and obesity as an exemplar of the impact and importance of prevention at a population level.

Vaccination

- The **winter influenza vaccination** campaign started for Health and Social Care staff on the 1st of September. The offer of COVID and Influenza vaccination for the eligible population will start from the 1st of October.
- During the Summer months the Health Board has been making **telephone calls to parents** of children who had missed one or both doses of **MMR** and our teams have delivered door to door **over 200 doses of the vaccine**. We also telephoned and/or texted every parent who did not return a consent form during the **HPV** campaign, this generated over 800 extra consents and we delivered 281 doses of HPV vaccination in community clinics. These catch-up efforts for both MMR and HPV will continue throughout the year to improve immunity, reduce the risk of a measles outbreak and address inequalities in vaccination.

Public Health

Tobacco

- **Communications** –videos of three case studies of successful quitters using the Help Me Quit Service have been distributed widely and are being shown to the public in 19 community Hubs across Cardiff and the Vale areas. The full video with all case studies has been viewed more than 5,000 times on Facebook alone (based on 2 separate posts) and 1,500 times on TikTok. Social media posts with still images of each case study were even more successful with a combined reach of 50,000.
- **Smoking Prevention and Young People –** Good progress made with establishing the 'Smoke Free Ambassadors Programme' in primary schools. Two primary schools will pilot the resources in the new academic year. Plans to share updates and learning on this innovative scheme via our Public Health newsletter and at the Public Health Wales Conference. Design and production of materials to reduce vaping among young people with 'Grassroots' youth group in Cardiff now complete and being disseminated.
- **Helping Pregnant Women and Birthing People Quit -** New 'Badgernet' referral system now operational; work underway with maternity colleagues to adapt some data fields to ensure the 'opt out' referral process previously established will continue with the new system (this will facilitate Help Me Quit service contact). Promotional activity to be delivered in Children's Hospital for Wales and Maternity Department as part of Patient Safety Day 17.9.25. Vaping and Pregnancy resource being developed in collaboration will be used at an all-Wales level when finalised.

Public Health

Substance misuse

- **Emergency Unit (EU) Alcohol Screening Project**: The UHB's Public Health Team has recently evaluated a test and learn project that offers alcohol screening and brief interventions to adults attending the UHW's EU, identifying its positive impacts as well as recommendations for improvement. Work is now ongoing to support the project's further development, through collaboration between the UHB's Public Health, APB (Area Planning Board) Support, EU and Safeguarding teams, and the Cardiff and Vale Drug and Alcohol Service (CAVDAS). The Cardiff and Vale APB have provided continued funding for the project, whilst it is further developed and embedded into 'business as usual'. A first meeting of a new quarterly EU Alcohol Screening Project Steering Group was held on the 18th August, to support strengthened monitoring, reporting and governance for the project.

- The **Buvidal Psychological Support Service (BPSS)**, commissioned by the Cardiff and Vale Area Planning Board, has been independently evaluated by the University of South Wales and found to be a clinically effective, trauma-informed model with high engagement and transformative outcomes for service users. The evaluation highlights BPSS's unique value in addressing a critical gap in psychological support for Buvidal recipients and will inform strategic planning for its continued development and potential expansion across Wales.

Women's Health Hubs

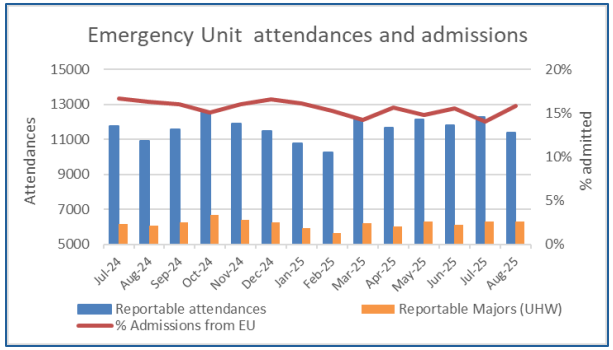
- CVUHB has submitted a **second round bid for pump-prime funding** to support the establishment of the 'pathfinder' hub. The result of this is due to be received from the Welsh Government in late September/early October.

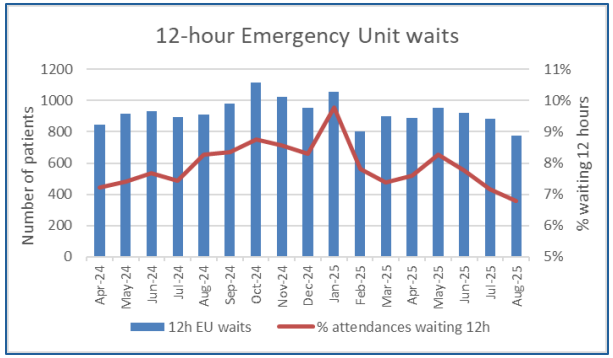
Health protection

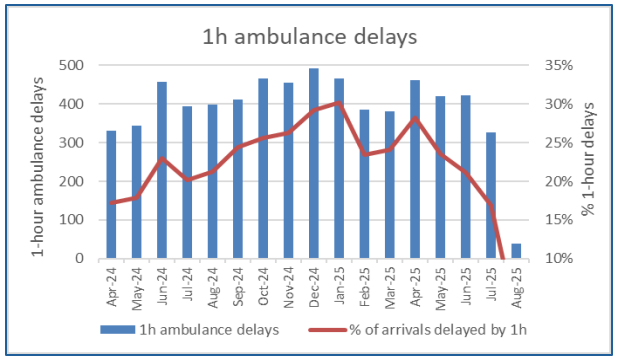
- The team will be engaged in a further meeting with Public Health Wales and all health boards in Wales in December 2025, to plan the **development of an elimination data dashboard** that will be crucial in tracking the health board's progress towards elimination targets for Hepatitis B and C, HIV and TB.
- Planning for Exercise Pegasus based on available information has been conducted. A paper was shared with the Strategic Leadership Team.

Urgent and Emergency Care – Out of Hospital and Front Door

- In August attendances at the Emergency Unit decreased from those in July but were increased compared to August '24. The number of Majors remained similar to July '25. The proportion of patients admitted via EU increased to 15.8% but is reduced when compared to August '24
- The summer has seen periods of significant operational pressure, impacting flow through the hospital and waits in the EU. Our organisational response including a "reset week" and business continuity-like actions in Medicine Clinical Board has led to some recent improvements
- The number of patients wating 12 hours or more in EU reduced in again in August and represented 6.8% of attendances. The number of patients waiting 24 hours in the EU footprint reduced to 2
- The number of 1-hour ambulance holds was significantly reduced in August – 2% of conveyances waited >1h at UHW. In line with the Ministerial Group recommendations, we have moved our operational focus to reducing and eliminating 45-minute ambulance holds. In August, the number of 45-minute holds at UHW reduced to 114 from 578 in July.

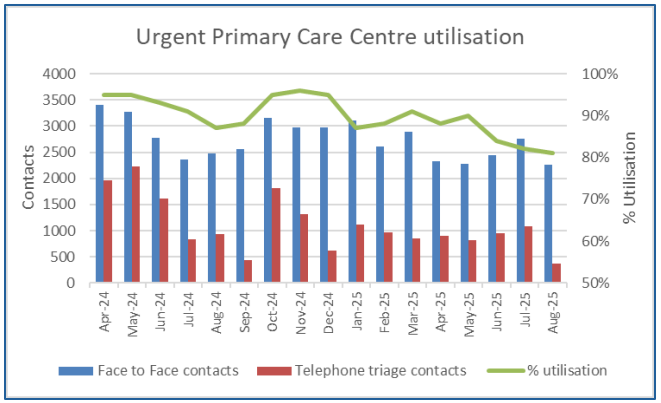




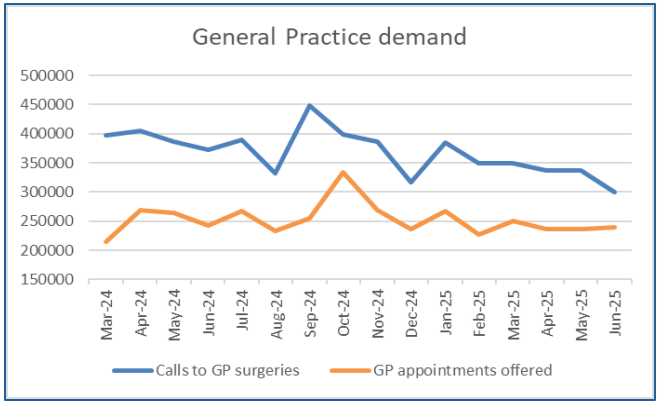


Urgent and Emergency Care – Out of Hospital and Front Door

- In August, over 2,250 patients attended Urgent Primary Care Centres across Cardiff and the Vale, with a further 369 patients triaged by telephone. In August 81% of the available slots were utilised
- In 24/25 there were over 4.5 million calls to GP surgeries, with over 3.1 million appointments offered
- Calls to surgeries has seen a downward trend over the past 3-years, while digital requests have increased
- The number of appointments offered in June increased slightly from the previous month
- We continue to see pressure across GMS with our primary care team supporting practices where required

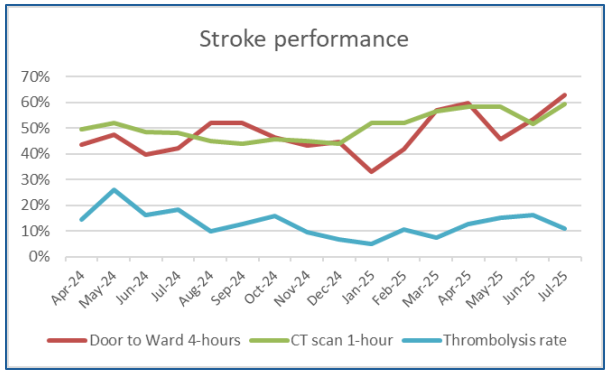


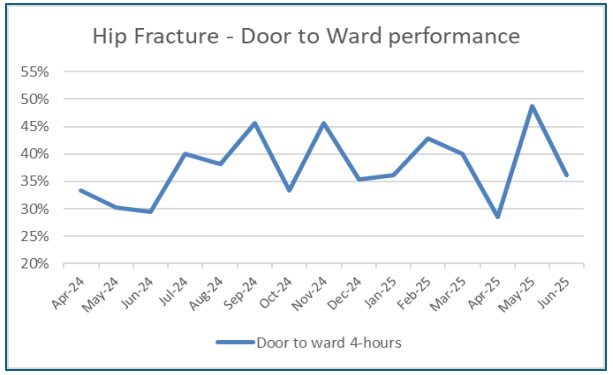
GMS activity	June 2025	Year to date 24/25
Calls to GP surgeries	299,062	973,280
Digital requests to GP practices	77,504	227,131
GP appointments offered	238,836	710,500
Items issued via presciption	749,932	2,145,753

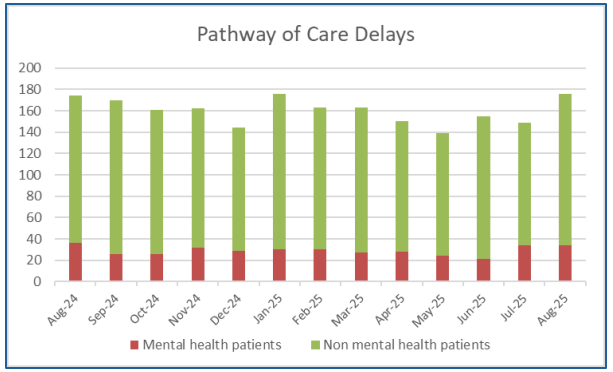


Urgent and Emergency Care – Hospital Flow and Discharge

- The most recent data from July showed an improvement in compliance with the Door to Ward standard for Stroke patients. Compliance rose from 53.6% to 62.9%. In July 59.5% of patients receiving their CT scan within 1-hour, increased from June
- In June, 36% of Hip Fracture patients were admitted to the ward within 4-hours. This represents a reduction in performance from May in line with the increased operational pressures in month, but remains significantly above the national average of 9%
- Pathway of Care Delays increased in August 2025 to 176, the number of non-mental health delays increased, mental health delays remained the same. We continue to focus on reducing delays and the length of inpatient stays, working with our partners in the local authorities to reduce delays throughout the assessment and discharge process







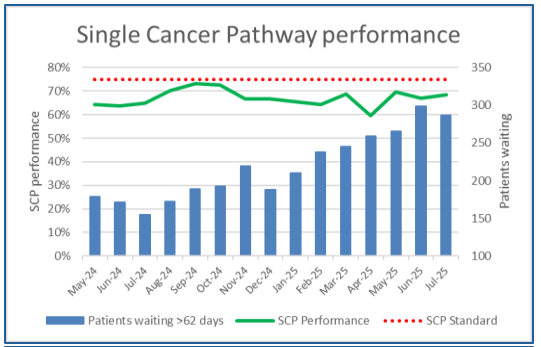
Planned Care, Cancer and Diagnostics

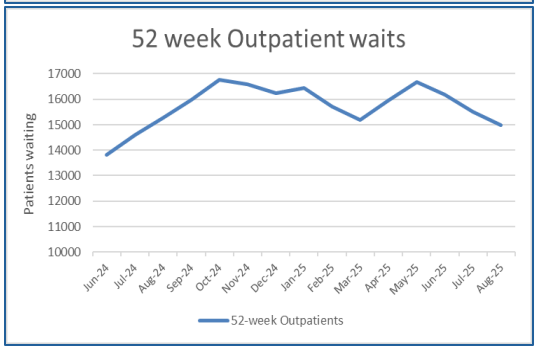
- The number of patients waiting >62 days for Cancer treatment has risen since last summer. In July compliance with the Single Cancer Pathway standard increased to 68.4%

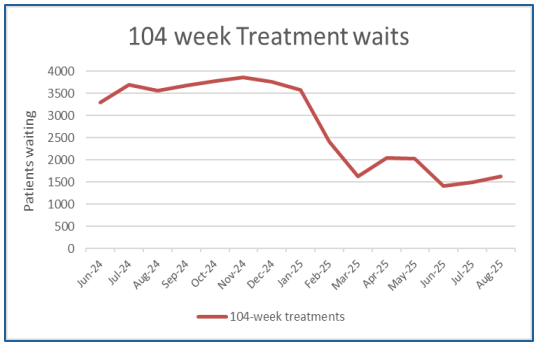
- The number of patients waiting 52-weeks for an outpatient appointment reduced in August 2025 driven by surgical specialties. We are working closely with Welsh Government on national schemes to undertake c33,000 additional outpatient appointments through this year. The first clinics took place in August and a monthly update will form part of future updates to F&P Committee

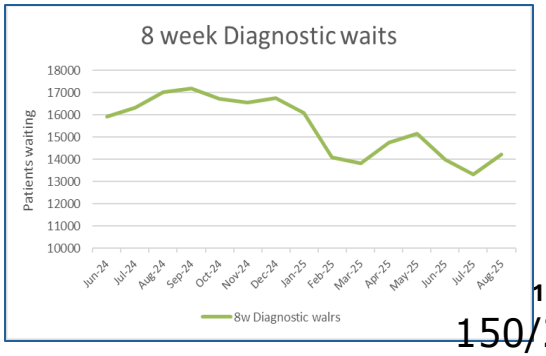
- The number of patients waiting 2-years for treatment increased in August to 1,622, in line with our trajectory. Following delivery of our commitment in Q1, we have committed to delivering a further reduction by the end of Q2. This is tracked daily, with weekly updates to the COO, CEO and Chair

- Diagnostic 8-week waits increased in August 2025 to 14,243, mainly driven by increased in Radiology waits. NOUS waits increase but remain lower than Q1. The MRI position increased by 450 patients. The 8-week position in Endoscopy remained stable



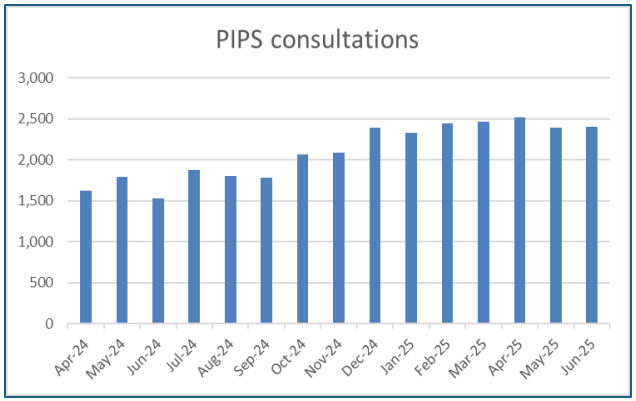


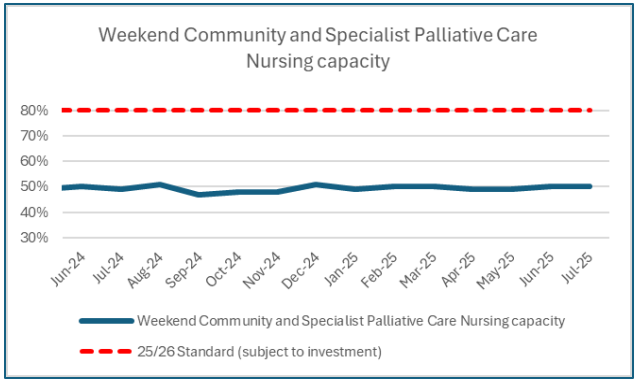


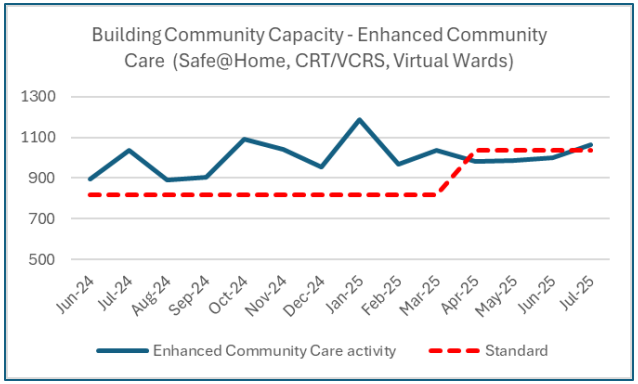


Primary and Community Care

- We continue to see demand pressures across Primary Care, with PCIC supporting practices at high escalation levels. Health Board monitoring reports 100% compliance with access standards through 24/25 and into Q1 25/26
- The General Dental Service delivered 98.5% of the contract value in 24/25. So far 23.4% has been delivered in 25/26, ahead of our delivery at this point last year
- Community Pharmacy continues to develop the Pharmacist Independent Prescribing Service, with 2,398 consultations delivered in June 2025, increased from May
- Our community teams continue to deliver a significant volume of activity to patients outside a secondary care setting. District Nursing contacts exceeds the number of visits to EU on a monthly basis and we have increased weekend capacity from 23/24 levels and look to increase further
- In 24/25 the Health Board exceeded the baseline for delivery of Enhanced community care capacity. We continue to develop these services, including a single point of access for enhanced community services, in July we met our ambition of a 20% increase this year

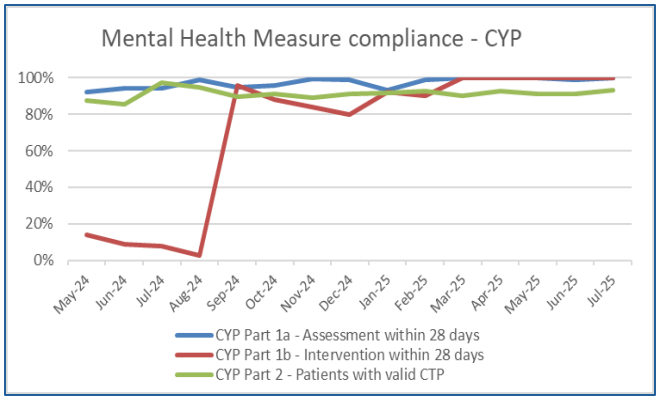


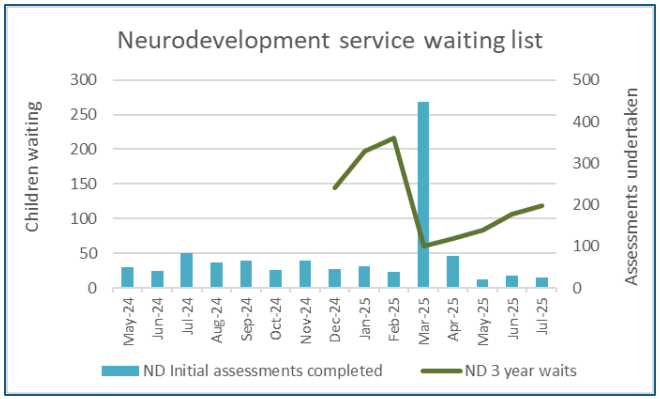


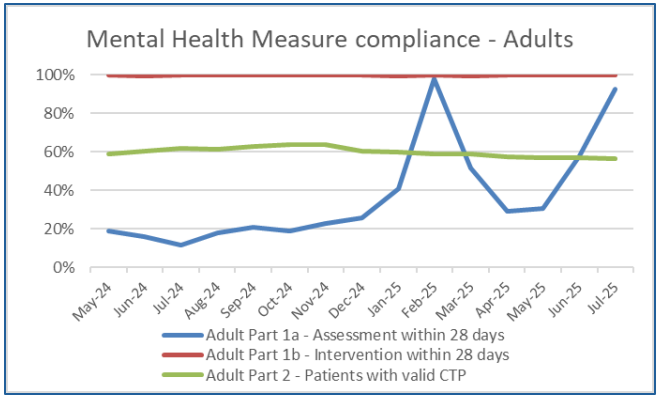


Mental Health

- For Children and Young People, Part 1a and 1b remain compliant despite high demand, 100% compliance reported for July 2025. Part 2 performance also remains compliant, with over 90% compliance maintained throughout 2025
- The Neurodevelopment service waiting list continues to grow with >560 referrals in June. The service anticipate the number of children waiting 3 years for assessment will grow throughout 2025 with the current capacity. The number of 3-year waits increased to 118 in July. In total there are 4,512 children on the waiting list for assessment
- For Adult and older people's mental health services, July saw an increase in Part 1a compliance to 92%, despite referrals remaining high. Part 1b remains compliant with 99.8% reported in July. Part 2 compliance remained low despite ongoing actions, a revised trajectory is being developed for September to reflect the need to address both performance and data submission challenges.





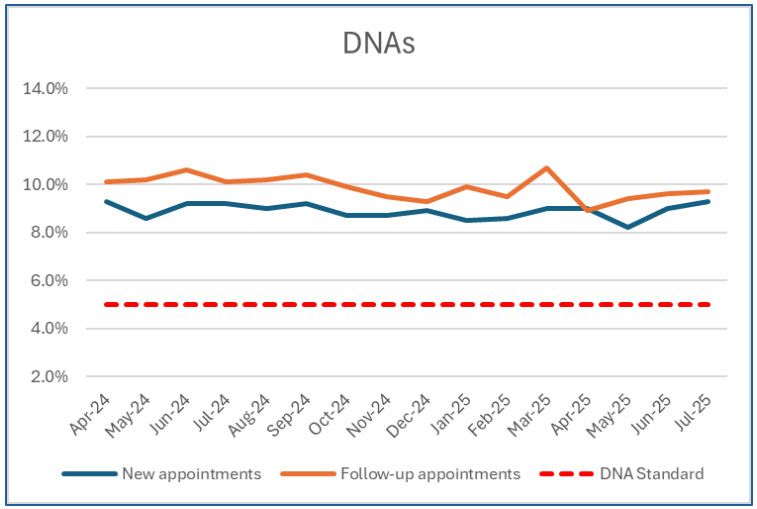


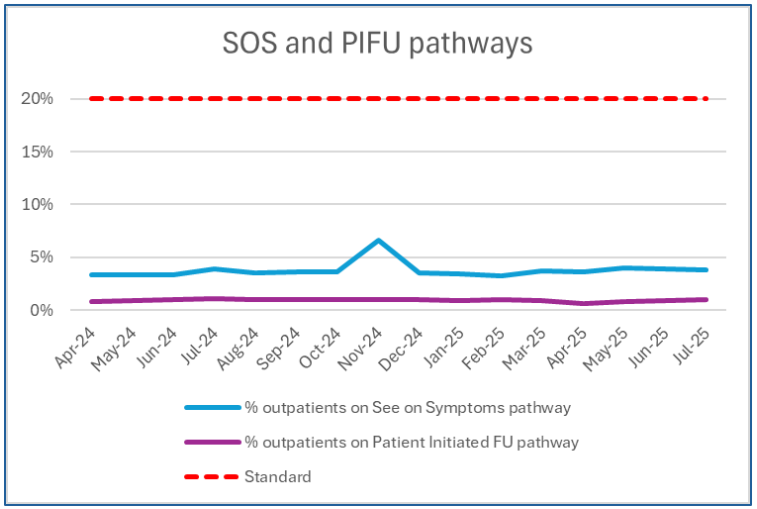
Mental Health Measures:
1a – assessments undertaken within 28 days
1b – therapeutic interventions undertaken within 28 days following assessment
2 – residents with a valid health and care treatment plan

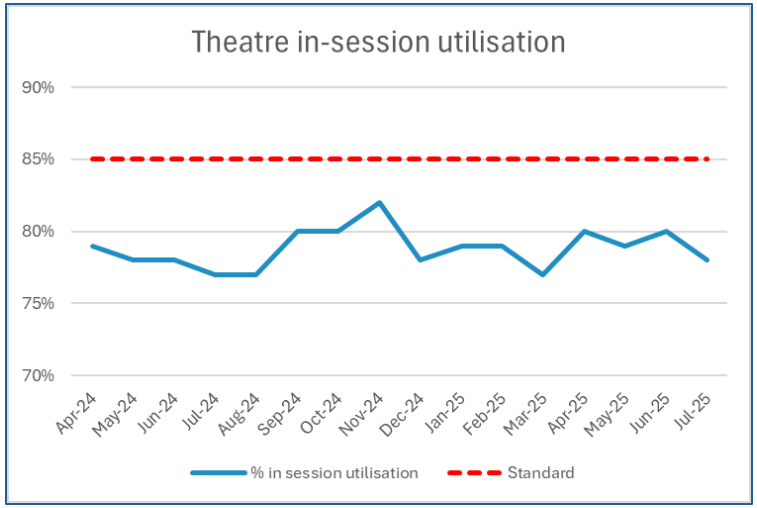
Productivity and Efficiency

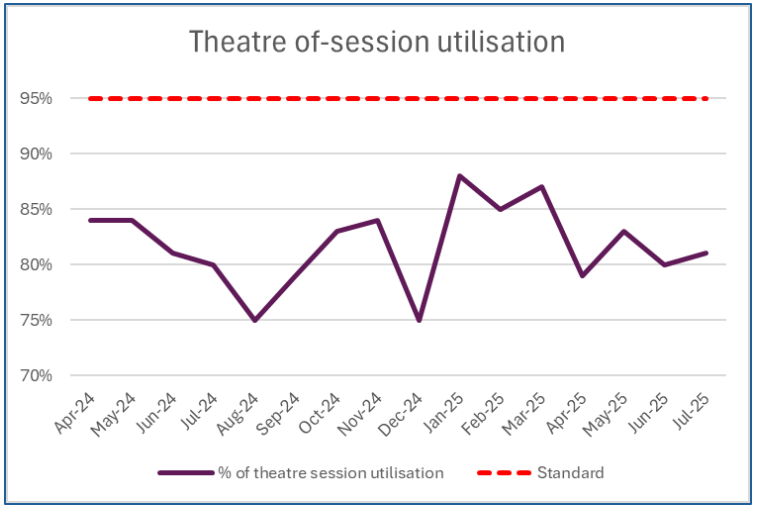
Measure		Standard	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend
Outpatients	% DNAs - New appointments	5%	9.2%	9.0%	9.2%	8.7%	8.7%	8.9%	8.5%	8.6%	9.0%	9.0%	8.2%	9.0%	9.3%	
	% DNAs - Follow-up appointments	5%	10.1%	10.2%	10.4%	9.9%	9.5%	9.3%	9.9%	9.5%	10.7%	8.9%	9.4%	9.6%	9.7%	
	% outpatients on See on Symptoms pathway	20%	3.9%	3.5%	3.6%	3.6%	6.6%	3.5%	3.4%	3.2%	3.7%	3.6%	4.0%	3.8%	3.8%	
	% outpatients on Patient Initiated FU pathway		1.1%	1.0%	1.0%	1.0%	1.0%	1.0%	0.9%	1.0%	0.9%	0.6%	0.8%	0.8%	1.0%	
Endoscopy	% room utilisation	90%	81%	74%	74%	68%	78%	75%	83%	82%	88%	78%	88%	81%	87%	
	% utilisation (activity points available)	95%	81%	80%	83%	85%	87%	85%	84%	81%	84%	87%	89%	87%	90%	
Theatres	Average turnaround time (minutes)	10	17.0	16.0	18.9	19.9	15.9	16.2	15.9	18.2	17.1	16.6	15.9	17.5	17.0	
	% of theatre session utilisation	95%	80%	75%	79%	83%	84%	75%	88%	85%	87%	79%	83%	80%	81%	
	% in session utilisation	85%	77%	77%	80%	80%	82%	78%	79%	79%	77%	80%	79%	80%	78%	
	<24 hour elective cancellations	N/A	309	249	190	363	198	217	315	295	347	237	229	281	287	
Waiting list	Total RTT waiting list volume	N/A	153,560	153,673	155,063	156,194	154,994	154,605	153,519	151,069	151,226	152,150	152,901	151,955	150,902	
Inpatient	Delayed pathways of Care - Mental Health	217	29	36	26	26	32	29	30	30	27	28	24	21	34	
	Delayed Pathways of Care - non-Mental Health		142	138	144	135	130	115	146	133	136	122	115	134	115	
	7 day LOS on Acute Wards (snapshot)	<40%	55.5%	58.0%	58.5%	59.4%	57.3%	62.3%	60.5%	59.4%	56.2%	57.8%	61.0%	59.3%	56.9%	
	21 day LOS on Acute Wards (snapshot)	<20%	30.9%	32.6%	31.8%	31.4%	30.9%	35.5%	37.3%	34.0%	34.0%	33.4%	33.4%	32.3%	32.0%	
	Medicine (all services) non-elective LOS (on discharge)	N/A	10.9	11.3	11.9	10.7	10.4	10.5	9.8	12.4	11.0	10.3	11.9	9.8	10.9	
Urgent and Emergency	Reportable attendances	N/A	11,773	10,926	11,567	12,628	11,922	11,468	10,756	10,237	12,193	11,659	11,517	11,823	12,304	
	Reportable Majors attendances	N/A	6,182	6,053	6,235	6,691	6,398	6,272	5,924	5,628	6,210	6,041	6,297	6,113	6,295	
	Reportable EU admissions	N/A	1,865	1,778	1,768	1,823	1,831	1,829	1,676	1,502	1,658	1,754	1,708	1,762	1,733	
	SDEC attendances	N/A	1,699	1,736	1,730	1,847	1,716	1,601	1,786	1,609	1,770	1,678	1,779	1,753	1,908	
Mental Health	TBC	TBC - will be added from Q3														

Productivity and Efficiency

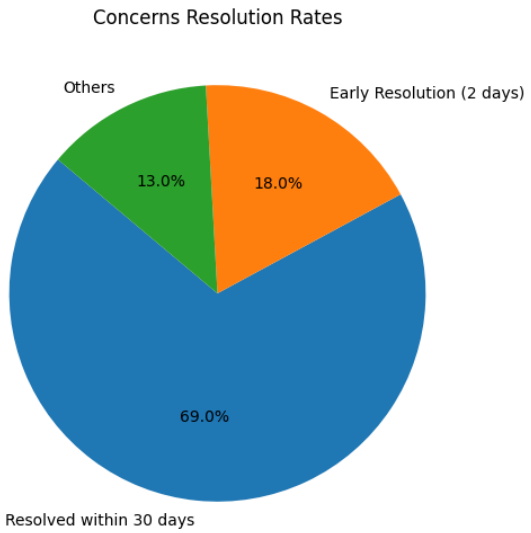








Concerns: August 25



Additional feedback included:

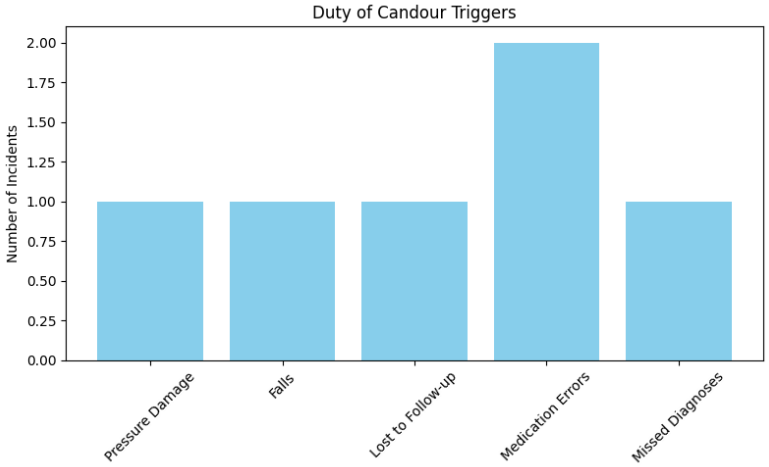
- **656 enquiries**
- **111 compliments**
- **339 active concerns** remain open

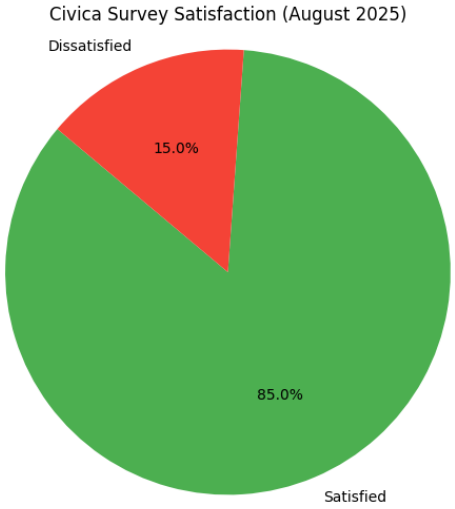
Top Themes:

- Clinical treatment and assessment
- Appointment-related issues (waiting times/cancellations)
- Communication

Key Themes:

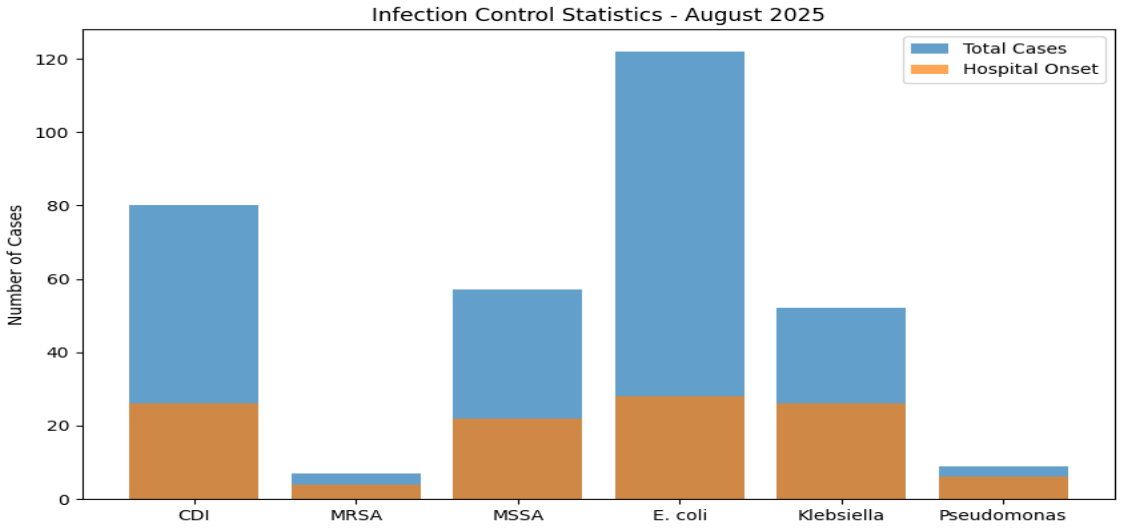
- Avoidable pressure damage
- Avoidable falls
- Patients lost to follow-up
- Medication errors (prescribing/administering)
- Missed diagnoses





In **August 2025**:

- **15,141 messages** sent
- **2,701 completed surveys** (18% response rate)
- **85% satisfaction** among respondents discharged in July/August



Clostridioides difficile (CDI)

- **Total cases:** 80 **Hospital onset:** 26
- This represents a **reduction of 28 hospital-onset cases** compared to the same period in 2024/25.
- **Ranking:** 2nd lowest rate among the six acute Health Boards in Wales.

Staphylococcus aureus (MRSA and MSSA)

- **MRSA cases:** 7 total, 4 hospital onset-Slight increase of 1 hospital-onset case compared to last year.
  - **Ranking:** 2nd highest rate in Wales.

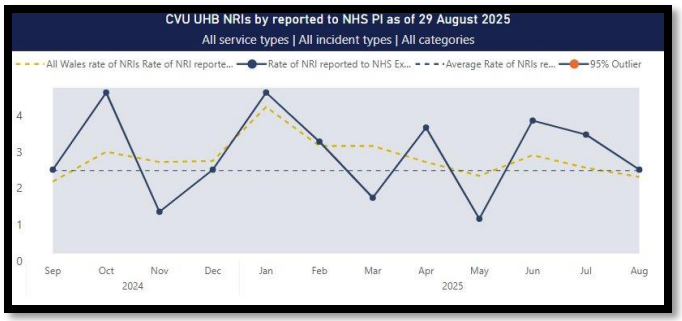
Escherichia coli (E. coli)

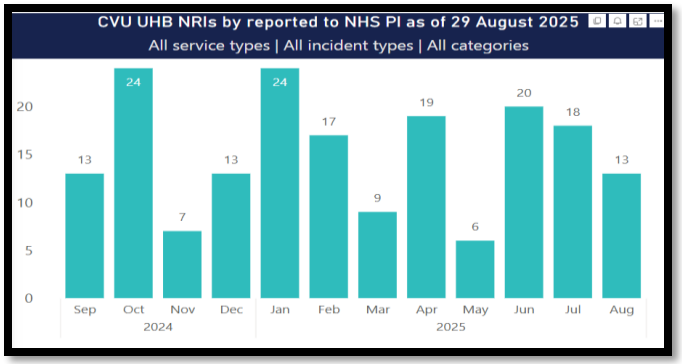
- **Total cases:** 122
- **Hospital onset:** 28
- Down by 8 hospital-onset cases compared to 2024/25.
- **Ranking:** Lowest rate among the six acute Health Boards.

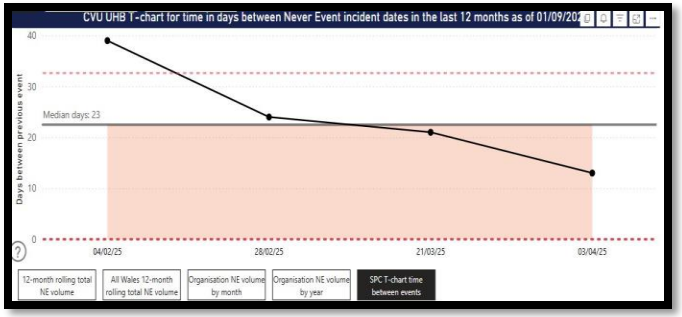
- The UHB Nationally Reportable Incidents (NRI) reporting rate in August 2025 was 2.31 per 100,000 population. Thirteen NRIs were reported in total during August 2025.

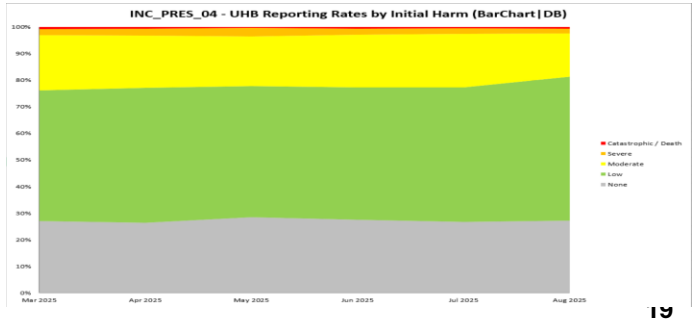
- There were 2335 patient safety incidents reported in August 2025 of which 390 were reported as resulting in moderate harm or above of these 63% have not been subject to an interim review by the first week in September. This is significant as initial reported harm is generally over estimated and 75% of those incidents initially recorded as resulting in moderate harm and above that have been subject to a review have been downgraded to no or low harm. However, 25% have been confirmed as having resulted in moderate harm or above and are therefore subject to the Duty of Candour and where deemed to have resulted in serious harm will require NRI reporting. All patient safety incidents should be subject to a timely review and robust fact finding and action to mitigate any risk.

- In response to the rising number of unreviewed and unmanaged patient safety incidents, the Patient Safety Team is offering targeted Datix engagement sessions for incident managers. These sessions aim to address specific challenges and provide support, ultimately equipping managers to effectively manage and close incidents. This initiative is intended to reduce the risks associated with a backlog of unreviewed patient safety incidents.







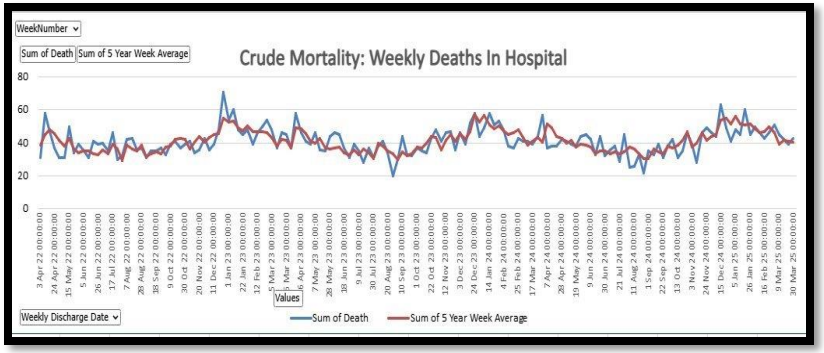


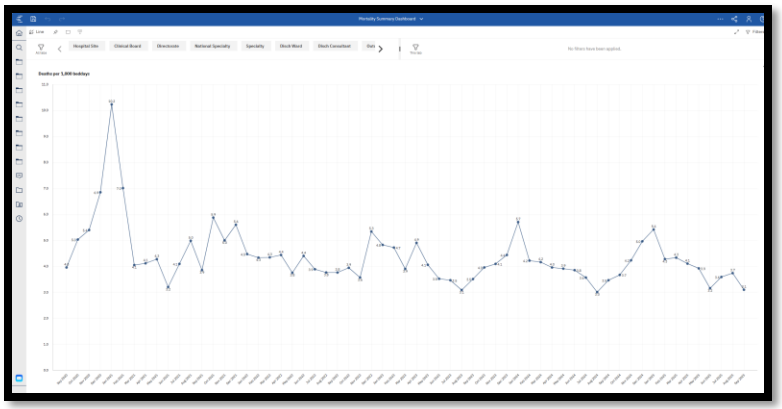
- The all-cause mortality rate across the Cardiff and Vale UHB area continues a similar seasonal pattern to the five-year average. Numbers of deaths are similar to the same period in the previous year. During week 31 of 2025, 94 deaths were registered in the CAV area, compared with 91 deaths registered during week 31 in 2024.

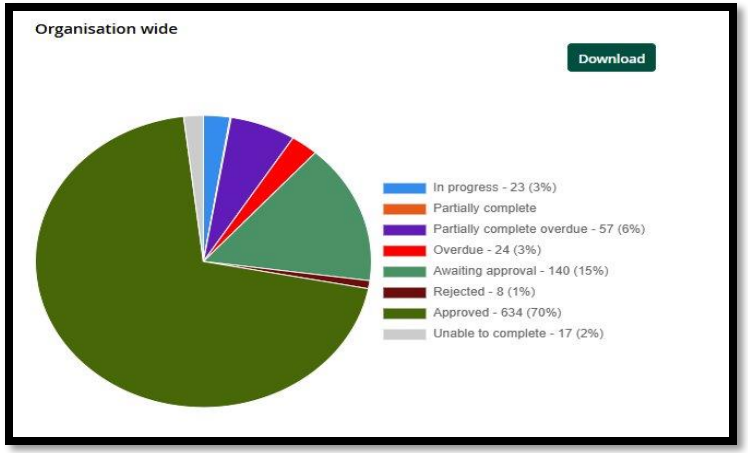
- The Medical Examiner scrutiny process continues to be a valuable source of information and learning for the Health Board. In 45 of the deaths occurring during July, the Medical Examiner provided feedback to the Health Board. Feedback themes included countersignature of DNACPR paperwork, delays in notification to the Medical Examiner of community deaths, and communication. The Health Board uses these themes to inform quality improvement work across a number of groups, such as the RADAR deteriorating patient group.

- The Health Board participated in an all-Wales learning event on 2nd September, which considered priorities for improvement in the care after death process and is making preparations ahead of Winter.

- HIW conducted a planned Ionising Radiation (Medical exposure) regulations (IR(ME)R) inspection of Diagnostic Imaging, University Hospital Llandough on 15 and 16 July 2025. No immediate assurance issues were identified during the inspection. The Inspection Report will be published on 16th October 2025.

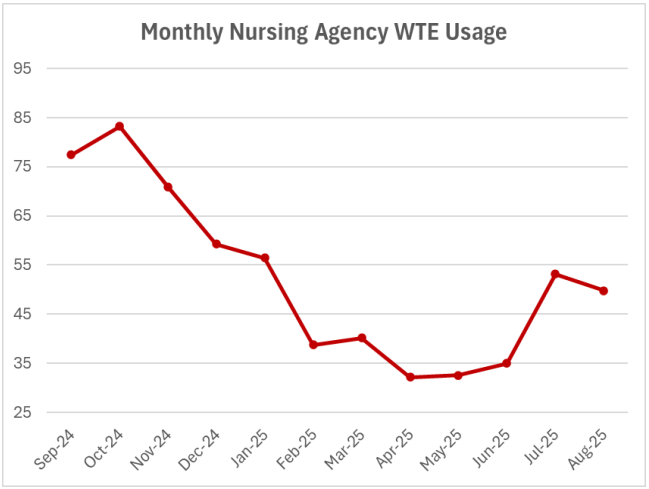


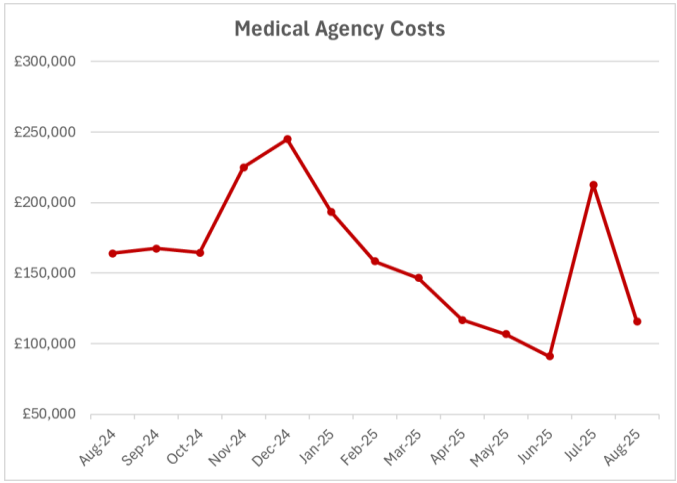




People and Culture

Agency Reduction continues to be a key focus, aligned to the WG Enabling action for 25/26. The graphs below show and overall shift reduction for the Nursing and Medical workforce. There is a decrease in use of agency in August despite school holidays, annual leave etc demonstrating improved management. The agency package for one patient who is moving between Critical Care and A7 continues at 2 RMNs and 2 HCSWs 24/7. This is all being delivered via an on-contract agency. Medical and Dental agency expenditure decreased by £97,037.66 between July 25 and August 25, supported by a reduction of five agency workers. Year-to-date (Months 1–5), our agency spend continues to track below the equivalent period in 2024/25.

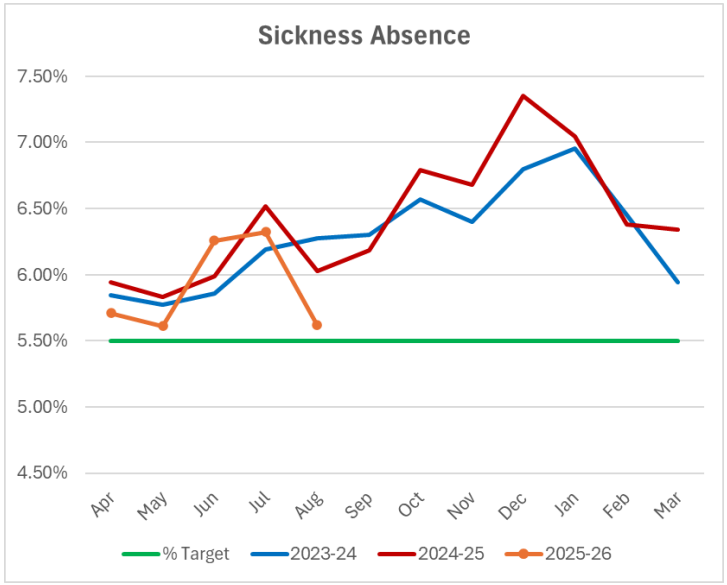




N.B There was a significant increase in July due to levels of annual leave as well as increased sickness absence. There was also a requirement for an additional agency care package in Medicine Clinical Board. For Medical Agency, in July there were 3 additional agency workers compared to June linked to extra capacity and vacant posts. £52,000 of the July costs are attributed to late submissions of timesheets from May and June 25.

Improving job planning compliance is a key priority. The WG enabling action is to **ensure > 90% of all Consultants have an agreed job plan in place at all times by 30 September 2025**. The plan to improve the position is monitored on a fortnightly basis as part of the agreed Medical & Dental workplan. Compliance has increased from 65.88% in March 25 to 76.33% in August 25. Approximately 120 job plans need to be completed to meet the target.

People and Culture



Improving Wellbeing and Attendance is a key priority for 2025/26. Actions taken include:

- Sickness absence rates are broadly following the normal yearly absence trend. The rates for April and May were below the rates for previous years, but the rate for Jul-25 was 6.32% i.e. higher than for 2023-24 (6.19%) but lower than 2024-25 (6.52%).
- Primary reason for absence is Anxiety, Stress and Depression – targeted wellbeing interventions and preventive methods are being utilised to reduce impact and support sustained attendance.
- Cough, Cold, Influenza is the second highest reason for sickness. Targeted promotion of the flu vaccine is taking place across Clinical Boards.

(n.b. the absence rate for the most recent month is subject to revision. Due to the enhancement date cutoff for nursing staff whose absence is managed using HealthRoster the absence for the first 2 weeks only of the previous month has been imported into ESR. It is common to see an increase of circa 0.50%-0.75% when the data is refreshed)

Workforce Planning:

In line with our Brilliant Basics approach, we have focused on strengthening Workforce Planning Capabilities within the UHB. Recently the UHB has:

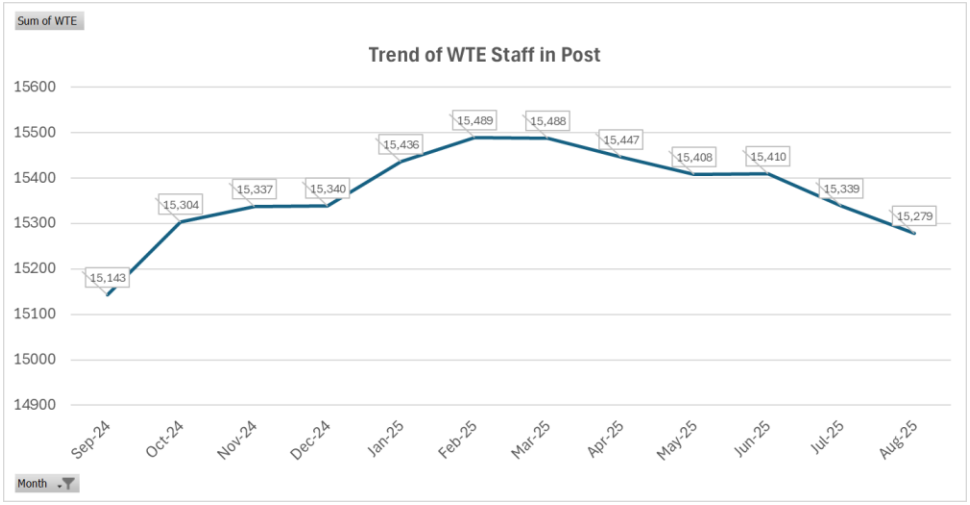
- Continued to promote the CAVUHB Workforce Planning and HEIW Workforce Planning SharePoint Sites.
- Sponsored requirement for all line managers to complete HEIW Introduction to Strategic Workforce Planning as a foundation level of knowledge.
- Presented papers to Management Executives outlining financial risks associated with Graduate Nurse student streamlining and other non-nursing professions graduate recruitment.

Leadership and Management:

- Also linked to our Brilliant Basic approach, the Senior Leadership Programme for Band 8C operational staff is launching on 26 September.
- Staff Survey - Clinical Board representatives are due to present action plans and progress at the next Focus Group (September 2025) and the OD team are actively promoting the launch of the 2025 survey on 6th October through engagement activity across the HB.

Workforce Reduction – Staff in Post

Row Labels	Sep-24 WTE	Oct-24 WTE	Nov-24 WTE	Dec-24 WTE	Jan-25 WTE	Feb-25 WTE	Mar-25 WTE	Apr-25 WTE	May-25 WTE	Jun-25 WTE	Jul-25 WTE	Aug-25 WTE	12-Month Change
Add Prof Scientific and Technic	581	580	585	583	596	598	601	602	598	598	600	601	20
Additional Clinical Services	2968	2955	2971	2957	2971	2995	3035	3010	3007	3007	2990	2969	0
Administrative and Clerical	2585	2587	2592	2597	2623	2639	2655	2649	2639	2640	2663	2644	59
Allied Health Professionals	1342	1295	1300	1297	1288	1276	1269	1270	1266	1267	1258	1268	-73
Estates and Ancillary	1236	1247	1249	1251	1253	1250	1216	1213	1202	1203	1193	1184	-52
Healthcare Scientists	587	584	592	599	600	599	559	566	565	565	562	554	-33
Medical and Dental	1106	1128	1137	1139	1146	1152	1157	1158	1159	1160	1150	1139	33
Nursing and Midwifery Registered	4721	4903	4884	4887	4925	4948	4970	4950	4945	4944	4901	4897	176
Students	16	25	28	30	34	32	27	28	26	26	24	23	6
Grand Total	**15143**	**15304**	**15337**	**15340**	**15436**	**15489**	**15488**	**15447**	**15408**	**15410**	**15339**	**15279**	**135**



As a result of the vacancy freeze put in place in January 2025 , the staff in post has reduced by 210 WTE since February 25 and 60 WTE in the past month.

An enhanced vacancy freeze was implemented in August where the Executives now require each Clinical Board Director of Operations to apply a higher level of scrutiny and then present in person any vacancies they feel are service critical and where the risk cannot be mitigated.

The annual recruitment cycle of graduate nurses, Midwives and AHPs as commenced, which will increase our current SIP position.

The target is to reduce the workforce by approx. 350 posts (approx. £4m) by 31/03/25.

Digital and Health Intelligence

Shaping Our Future Digital Services

The team continues to focus on improving the digital infrastructure – extending the Wi-Fi access across our main sites and replacing older end user devices (laptops and PCs), funded through capital monies. Progress on these projects are included in the main Integrated Performance Report. Digital and data requirements continue to be an organisational priority in the short to long-term with these captured in the Digital Foundations programme business case, which has now been produced.

Digital Eyecare – Update

- Swansea Bay University Health Board has successfully implemented the digital eye care system OpenEyes for all sub-specialties across the Ophthalmology directorate. The CAV UHB digital team provided direct support for the go live day in Singleton Hospital on 8th September. SBUHB is planning further service enhancements and the deployment of OpenEyes in Community Optometry for the electronic delivery of WGOS02 and WGOS04 services as part of the national digital eye care programme being led and managed by CAV Digital team.
- CAV Digital team are supporting both Aneurin Bevan and Cwm Taf Morgannwg University Health Boards ahead of planned implementations of OpenEyes starting in November 2025. Initial meetings have also been held with Hywel Dda UHB and Betsi Cadwaladr UHB to start the planning for their respective deployments.

Digital Service Management – Update

- The Digital Programme Management Office has commenced Phase 2 of its grip and control over the organisation's digital work programme. Reporting is being worked upon from the rich MicroSoft Project Accelerator platform data not recorded.
- Formation of the Lost to Follow up (LTFU) programme of work is underway with Shaping Change colleagues. This will be a large body of digital development across outpatient services in 2025/26.
- Engagement with Welsh Government and DHCW to instigate the feed into the NHS Wales patient App programme.
- WECDS (Emergency Care Data Set) – Demonstration of the stand-alone 'UEC App' being undertaken to evaluate whether it's capable of delivering clinical and reporting requirements.
- MHCS 2 (PARIS system replacement) - £500k has been made available for foundational works to be delivered in 2025/26.
- The Digital care Region (DCR) programme plans an implementation of CRT viewer for Cardiff and Vale organisations in October'25.
- The team continues implementation management of the electronic Prescribing and Medicines' Administration system as its deployed across the organisation over the next six months.
- Cloud deployment – a Landing Zone is due for LIVE release in November 2025.

Digital Operations – Update

- The Telecoms Team continues to modernise communication infrastructure, including Vocera and Bleep System upgrades. These enhancements will significantly improve clinical communications and operational efficiency.
- The Network Team is leading the Wi-Fi Upgrade Project, which has expanded from ePMA clinical areas to include CEF departments like catering, portering, and cleaning. A project dashboard has been development to monitor coverage and project performance. Recent audits identified 189 areas requiring improvements. These upgrades are critical to ensuring high-speed, secure connectivity across clinical and non-clinical environments
- As part of the all-Wales INFRAM initiative led by Digital Health and Care Wales (DHCW) and supported by Cisco, the teams are actively coordinating with a dedicated Digital Project Manager for the local delivery of the Infrastructure Adoption Model (INFRAM) assessment. This assessment evaluates the organisation's digital maturity across five critical domains: Cybersecurity, Adoption, Sustainability, Performance, and Outcomes, using the HIMSS 8-stage model. Working with designated leads for each domain to gather structured responses through Cisco-facilitated workshops and surveys creating a tailored roadmap for infrastructure improvements, focusing on building a secure, resilient, and future-ready IT environment that enhances data sharing and patient outcomes. The assessment begins in late September 2025.

Digital Foundations – Update

The Digital Foundations programme has completed a set of engagement workshops with a wide range of clinical and operations stakeholders . The Programme Business Case (PBC) and related Year 1 Business Justification Cases (BJCs) have been completed and will be presented to various CAV governance meetings, the first of which is 15th September. It is anticipated that additional revisions will be made throughout this process in preparation for submission to the Welsh Government Capital Investment Group later this year.

Business Intelligence Information – Update

- New Emergency Unit Task List dashboard has been developed and released
- Work has started to establish reporting of regional ophthalmology and insourcing activity
- Work is progressing with Trustmarque on guardrails for the full rollout of Power BI
- Two new Business intelligence Partners are now in post to bolster internal data insights reporting and data modelling capacity

Digital Transformation– Update

- The Colposcopy service is live on the PAS (PMS) system - some post live actions including an amendment to WRAPPER encounters feed to include a next appointment required flag and date (for reporting).
- The Business Analyst is seconded to the Pathology IT team to support the service taking on the new laboratory system (LIMS 2) transition over the next 6 months.

Recommendation:
The Board/Committee (*delete as appropriate*) are requested to: a) **NOTE** the year to date position against key organisational performance indicators for 2025-26 and the update against the Operational Plan programmes.

Link to Strategic Objectives of Shaping our Future Wellbeing: *https://shapingourfuturewellbeing.com/*			
Putting People First	Providing Outstanding Quality	Delivering in the Right Places	Acting for the Future
1. **Click the objective above to view more detail.**	2. **Click the objective above to view more detail.**	3. **Click the objective above to view more detail.**	4. **Click the objective above to view more detail.**
	x	x	

Five Ways of Working (Sustainable Development Principles) considered				
Prevention	Long term	Integration	Collaboration	Involvement
	x	x		

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***	x	Not required

Impact Assessment:	
Risk: No	Reputational: No
Safety: No	Socio Economic: No
Financial: No	Equality and Health: No
Workforce: No	Decarbonisation: No
Legal: No	Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before)*:	
Committee/Group/Exec	Date:

Cardiff and Vale
Integrated Performance Report

2025/26

September 2025

Report Contents

Click on a hyperlink to navigate directly to the section required

Section 1: Cabinet Secretary Priorities

Return to Main Menu

The Cabinet Secretary for Health and Social Services has set out National Programmes of work covering the priority areas of delivery. These priority areas are:

- Timely access to care
- Population health and prevention
- Building community Capacity
- Mental health access
- Women's health

Further to these priority areas the Welsh Government and NHS Wales have identified Key Delivery Expectations across Urgent and Emergency Care, Cancer, Diagnostics, Elective Care and Mental Health Services.

Section 1 provides an overview of the Health Board performance of the Key Performance Indicators outlined by Welsh Government and Health Board commitments related to the delivery of the priority areas.

For a more in-depth view on performance for each priority, please follow the links in the NHS Performance Report column.

Performance ambition for 25/26 are in line with our annual plan, which has not been agreed with Welsh Government

Section 1: Cabinet Secretary Priorities

Return to Main Menu

Priority	Aim	C&V Commitment	Commitment to meet national standard?	By When	In Month Performance against C&V commitment	Link in Performance Report
Building community Capacity	**Measure:** Number of delayed transfers of care. **National standard/ambition:** 12 month reduction trend **Reporting period:** Monthly	**<160**	**Yes**	**Q4**	**176** Aug-25	Hyperlink to section
	Measure: General Medical Services – Number of GP practices achieving core access standards **National standard/ambition:** 100% **Reporting period:** Annual – in month position for information	**100%**	**Yes**	**Q4**	**98.2%** Apr-24	Hyperlink to section
	Measure: Increase in number of people accessing Pharmacist Independent Prescribing Service for acute minor conditions and routine contraception **National standard/ambition:** Increase **Reporting period:** Monthly	**>2,185**	**Yes**	**Q2**	**2,398** Jun-25	Hyperlink to section
	Measure: Increase in capacity at the weekend of community nursing and specialist palliate care **National standard/ambition:** 80% **Reporting period:** Monthly	**>51%** Increase from 24/25	**No**	**Q4**	**50%** Jun-25	Hyperlink to section
	Measure: Increase capacity of Enhanced Community Care **National standard/ambition:** Meet and exceed 24/25 requirement where possible (24/25 baseline) **Reporting period:** Monthly	**1,038** 20% increase from 24/25	**Yes**	**Q1**	**1,001** Jun-25	Hyperlink to section

Performance Key: Meeting standard / trajectory | off target/trajectory

Section 1: Cabinet Secretary Priorities

Return to Main Menu

Priority	Aim	C&V Commitment	Commitment to meet national standard?	By When	In Month Performance against C&V commitment	Link in Performance Report
Population health and prevention	**Measure:** Increase in % of patients (aged 12 and over) with diabetes who received all eight NICE recommended care processes **National standard/ambition:** Increase **Reporting period:** Monthly	48%	Yes	Q4	46.1% Jun-25	Hyperlink to section
Mental health access	**Measure:** Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of referral for people age under 18 years **National standard/ambition:** 80% **Reporting period:** Monthly	80%	Yes	Q1	100% Jul-25	Hyperlink to section
	Measure: Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of referral for adults age 18 years and over **National standard/ambition:** 80% **Reporting period:** Monthly	80%	Yes	Q1	99.8% Jul-25	Hyperlink to section
	Measure: Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years **National standard/ambition:** 80% **Reporting period:** Monthly	80%	Yes	Q1	100% Jul-25	Hyperlink to section
	Measure: Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over **National standard/ambition:** 80% **Reporting period:** Monthly	80%	Yes	Q1	92.4% Jul-25	Hyperlink to section

Performance Key: Meeting standard / trajectory | off target/trajectory

Section 1: Cabinet Secretary Priorities

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Priority	Aim	C&V Commitment	Commitment to meet national standard?	By When	In Month Performance against C&V commitment	Link in Performance Report
Timely access to care	**Measure:** Reduce the number of ambulance patient handovers over 1 hour **National standard/ambition:** Zero **Reporting period:** Monthly	**<400**	**No**	**Q4**	**39** Aug-25	Hyperlink to section
	Measure: Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge **National standard/ambition:** Reduce compared to 24/25 towards zero **Reporting period:** Monthly	**<750**	**Yes**	**Q4**	**774** Aug-25	Hyperlink to section
	Measure: Number of patients waiting more than 104 weeks for treatment **National standard/ambition:** Zero **Reporting period:** Monthly * Our commitment is subject to review as we work with Welsh Government through the year to deliver an improved position	**Original Submission 9,861** **Revised submission 5,491**	**No**	**Q4**	**1,622** Aug-25	Hyperlink to section
	Measure: Improve the percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of referral route) **National standard/ambition:** 12m improvement trend towards 80% by March 2026 **Reporting period:** Monthly	**75%**	**No**	**Q4**	**68.4%** Jul-25	Hyperlink to section
	Measure: Number of patients waiting more than 8 weeks for a specified diagnostic **National standard/ambition:** Zero **Reporting period:** Monthly	**Original submission 10,436 (endoscopy only) - TBC**	**No**	**Q4**	**14,243** Aug-25	Hyperlink to section

Performance Key: Meeting standard / trajectory | off target/trajectory

Section 2: Cardiff and Vale Performance Report

The Performance Report section provides detail of UHB performance across the quadruple aims.

Detail on what is included under each quadruple aim is provided below.

A summary of performance is provided against the priority UHB ambition under each aim, including detail of annual plan commitments. Performance against the relevant NHS Performance Frameworks measures is provided under each aim.

National Performance Framework monitoring data is available from DHCW showing performance across all Welsh Health Boards and Trusts (where relevant). This information can be accessed by clicking here.

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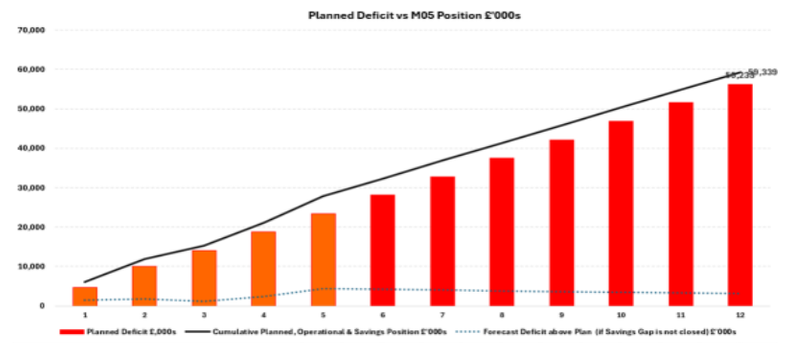
Number	Aim	Contents
Aim 1	People in Wales have improved health and well-being with better prevention and self-management	Public Health
Aim 2	People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	Urgent and Emergency Care Inpatient Flow, Discharge and Front Door Alternatives to Admission Community and Urgent Primary Care Priority Services RTT Waiting Times Planned Care Cancer, Diagnostics and Therapies Primary and Community Care Whole System Evaluation and Supporting Patients Whilst Waiting Mental Health
Aim 3	The health and social care workforce in Wales is motivated and sustainable	People and Culture
Aim 4	Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes.	Quality, Safety and Experience Financial Performance

Financial Performance

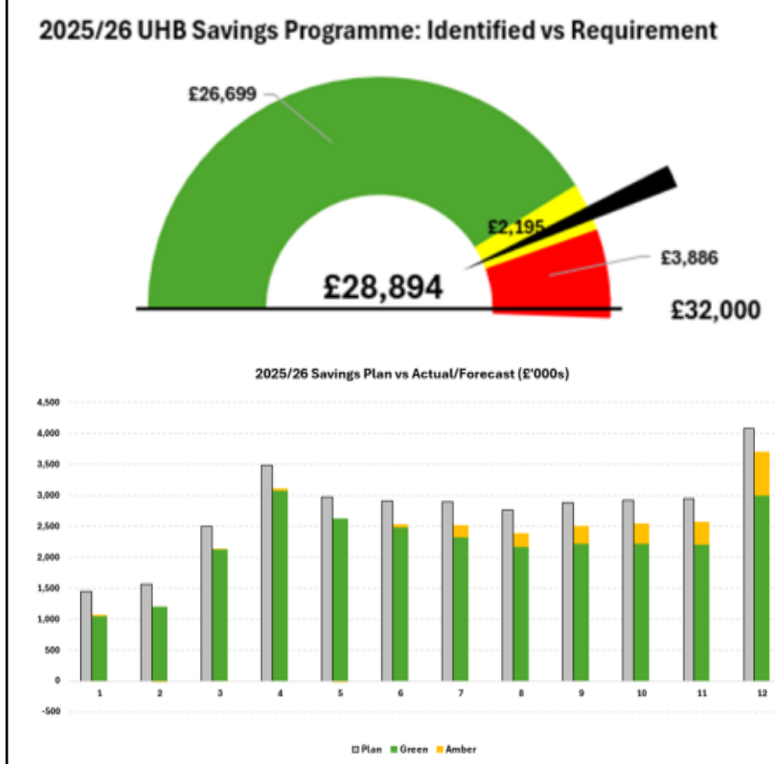
Priority	Performance Summary	Reported Period	Data
Deliver 2025/26 Draft Financial Plan	**The UHB's Financial Plan in 2025/26 reflected the following key components:** The initial planned deficit of £58.2m was noted by the UHB for submission to Welsh Government at the end of March 2025. Welsh Government asked the UHB to detail further actions to reduce the forecast deficit of £58.2m. In response, the UHB confirmed that progress in the identification of savings provided sufficient assurance to increase planned savings delivery by £2m and reduce the forecast 2025/26 deficit position to £56.2m. The submitted plan projects a deficit for the financial year and therefore a failure of the UHB's statutory requirement to deliver a balanced financial plan over a 3-year rolling period. This also prevents Ministerial approval of the plan. The overall position at month 5 was a £27.809m deficit as outlined in the table.	August 2026	
Return to financial balance and approved IMTP status	£56.2m underlying deficit by end of 2025/26 financial year. The UHB is reporting a savings gap of £1.466m and an operational deficit of £2.913m at Month 5. The savings gap and operational pressures would lead to an increase in the underlying deficit in 2025/26 if further savings or mitigating actions are not identified as the year progresses.	August 2025	
Management of operational budget pressures	Failure to adequately manage budget pressures. This is the responsibility of the primary budget holders. £2.913m operational deficit reported at month 5. Year to date operational variances are partly abated and managed by vacancies across non-medical staff groups and non recurrent underspends in non pay areas . It is anticipated that the unachieved CRP gap and operational pressures at month 5 will be managed and mitigated as the year progresses and that the UHB will deliver its planned deficit position of £56.200m. A number of additional urgent control actions were implemented in January 2025 to slow expenditure run rates and eliminate unnecessary expenditure. A vacancy freeze has been introduced from August 1st and additional capacity will only be commissioned where absolutely necessary.	August 2025	

Planning Assumptions	(£m)
Brought Forward Underlying Deficit	59.900
2025/26 Demand/Cost Growth/Improvement	51.100
Draft Deficit	**111.000**
Additional Allocations	(22.768)
Savings Plans	(32.000)
Initial Planned Deficit	**56.233**

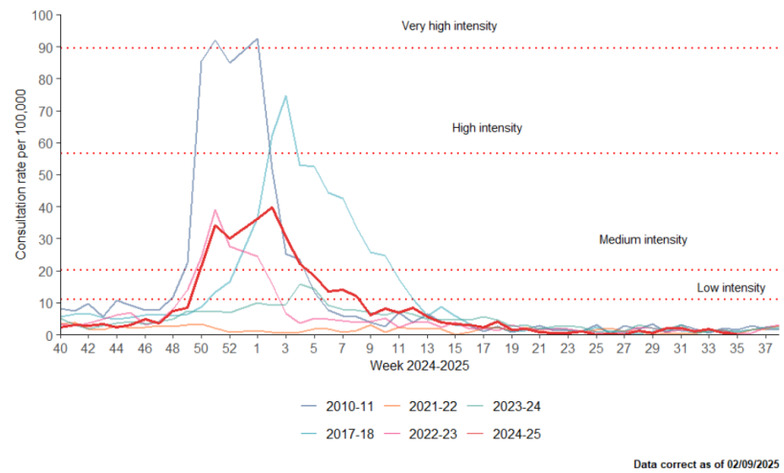
	Plan YTD (£m)	YTD (£m)	YTD Variance to Plan (£m)
Draft Plan	35,017	35,017	0
Quality Efficiency Improvement Plans - Savings	(11,587)	(10,121)	1,466
Operational Variance	0	2,913	2,913
Clinical / Service Board Variance	**23,430**	**27,809**	**4,379**

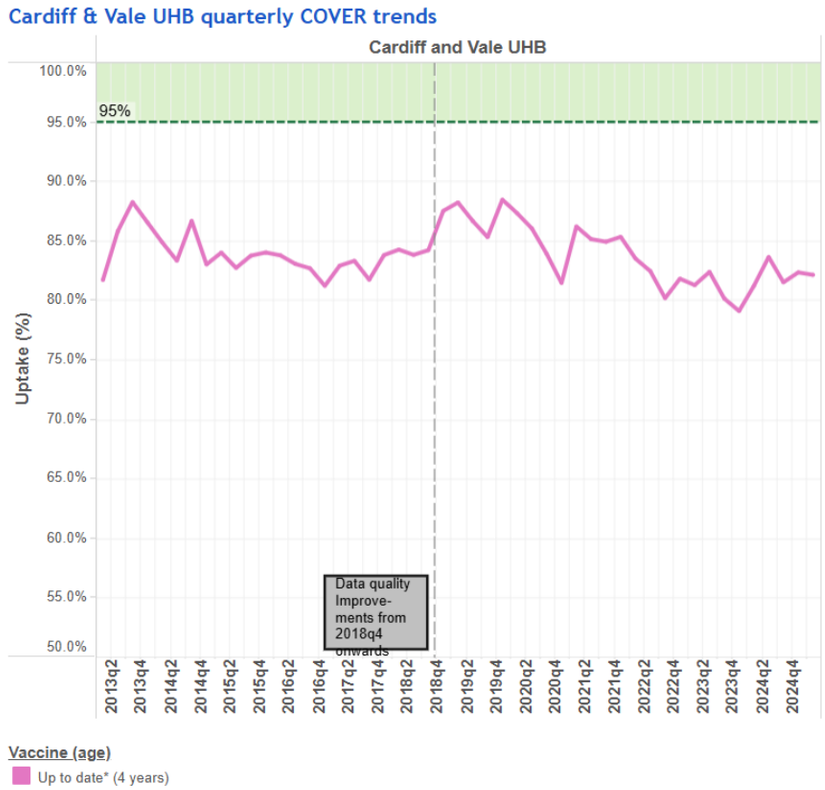
	1	2	3	4	5	6	7	8	9	10	11	12
Planned Deficit £,000s	4,686	10,096	14,058	18,744	23,430	28,117	32,803	37,489	42,175	46,861	51,547	56,233
Cumulative Planned, Operational & Savings Position £'000s	6,096	11,899	15,216	21,172	27,809	32,313	36,818	41,322	45,826	50,330	54,835	59,339
Forecast Deficit above Plan (if Savings Gap is not closed) £'000s	1,410	1,803	1,158	2,428	4,379	4,197	4,015	3,833	3,651	3,470	3,288	3,106
24/25 deficit outturn of £27.7m	6,096	11,899	15,216	20,149	20,149	20,993	22,117	23,241	24,365	25,489	26,613	27,737

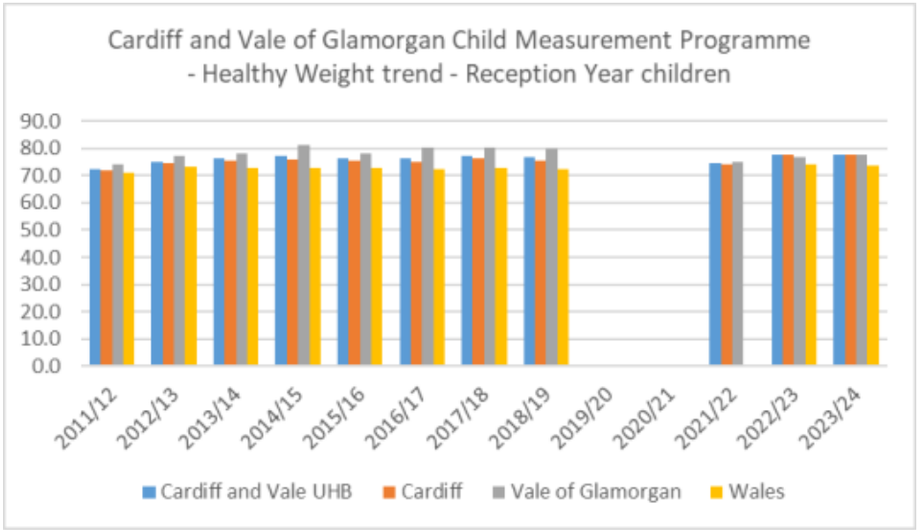
Operational Pressure	Operational Variance YTD £'000s	Operational Variance Forecast £'000s
Mental Health Out Of Area Placements (OOA)	1,200	1,003
Specialist Services Activity Related Underperformance	1,600	0
Employers NI (ENIC) Funding Gap	894	2,145
JCC Forecast Outurn Growth	200	1,036
Medical Staff Banding Arrears	300	300
GP Out of Hours pay resolution	1,000	1,000
Prescribing & Childrens CHC Growth	200	0
Pay Vacancies & other mitigating actions to be agreed	(1,015)	(5,484)
Sub-Total Surplus/Deficit	**4,379**	**0**

	Priority	Performance Summary	Reported Period	Data
	Delivery of recurrent £32.0m savings target	At Month 05, the UHB had identified £28.894m (90.2%) of green and amber savings to deliver against the revised £32.0m savings target. Red schemes of £3.886m are also identified and continue to be reviewed for progression to Green/Amber where possible. The reported in year gap of £3.106m in identified savings incorporates red schemes and the unidentified balance. Some of the savings identified in 2025/26 are non recurrent. The gap against the recurrent savings target was £8.480m at month 5. The second chart illustrates that the profile of the UHB's 2025/26 savings programme is skewed towards the end of the year.	August 2025	
	Remain within Cash Limit	The UHB will require cash support from WG for the 2025/26 revised planned deficit of £56.2m along with an estimated £17m in working capital for movements from the 2024/25 balance sheet. The closing cash balance at the end of August 2025 was £3.447m. The cumulative cash drawn at the month end against the UHBs cumulative annual cash drawing limit is illustrated by the graph to the right	August 2025	

Priority	Performance Summary	Reported Period	On target?	Data

Health Protection	**Seasonal respiratory infections**
	
	Vaccination – COVID-19 and influenza
	• The Autumn Winter vaccination campaign has started for health and social care staff from the 1st of September, and it will start for all eligible population groups from the 1st of October
	
	Surveillance
	• Respiratory surveillance summary (All Wales)
	  • Influenza circulation remains at baseline levels. GP consultations for influenza-like illness and confirmed case numbers have remained stable in the current week, as has test positivity.
	  • COVID-19 case numbers have remained broadly stable in recent weeks.
	  • RSV is at baseline levels.
	• Hospital incidents and outbreaks (C&V)
	  • There is currently **1** Covid-19 outbreak and **0** incidents in hospitals in C&V UHB; and **0** influenza outbreaks and **1** incident.
	  • Since the start of the 2025/26 financial year, in C&V UHB there have been **9** influenza incidents or outbreaks, with **41** bed days lost. In the same period there have been **57** Covid-19 incidents or outbreaks, with **225** bed days lost. Combined, influenza and Covid-19 incidents and outbreaks have led to the **loss of 266 bed days**, representing an estimated opportunity cost of **£133,000** to the UHB
	• Staff sickness absence (C&V)
	  • Financial year to date (Apr 2025-Aug 2025 inclusive):
	  • **12,094 full time equivalent calendar days*** were reported as sickness absence by C&V UHB staff due to respiratory conditions (S15), cough, cold or flu (S13)
	  • The estimated loss in productivity due to this absence is **£1.38m†**
	
	* Because of the way absence is recorded on ESR these figures include weekends and non-working days
	† Salary costs for staff reporting sickness absence
		Data to 4/9/25	Below target, but above Wales average	**Table 2b.** Coverage of the 2025 Spring COVID-19 vaccination campaign in eligible population, counting those alive and resident in Wales as at 05/08/2025, by Local Health Board of residence.
				
				Local Health Board of Residence / Eligible population (n) / Vaccinated (n) / Coverage (%) / Of those vaccinated, number with no previous doses (n)
				Aneurin Bevan UHB 78,387 44,284 56.49 17
				Betsi Cadwaladr UHB 104,363 57,939 55.52 35
				Cardiff and Vale UHB 56,069 31,846 56.80 21
				Cwm Taf Morgannwg UHB 56,792 31,074 54.72 11
				Hywel Dda UHB 61,258 24,077 39.30 28
				Powys THB 23,169 13,182 56.89 18
				Swansea Bay UHB 50,288 26,803 53.30 7
				All Wales 430,326 229,205 53.26 137
				
				Source: Source: Wales COVID-19 Vaccination Weekly Surveillance Summary
				
				 
				
				Source: PHW weekly ARI summary

Priority	Performance Summary	Reported Period	On target?	Data
Health Protection	**Routine childhood immunisation** • At 4 years of age, 82.1% of children are up to date with vaccination, which is an improvement year on year, below the target of 95% and a Welsh average of 85.3% • At 5 years of age, 84.6% of children are up to date with vaccinations, a level which is still below the Welsh average of 87.5%. • Awaiting quarterly COVER report for April-June 2025	01/01/25 - 31/03/25	In line with local targets, below national targets.	 Source quarterly COVER data

Priority	Performance Summary	Reported Period	On target?	Data
Health Improvement	**Healthy weight:** • 2023/24 Child Measurement Programme data demonstrated a slight increase in healthy weight to 77.7%, from 77.5% the previous year (for Cardiff and Vale UHB). The UHB had the highest level of healthy weight of all Welsh Health Boards for 2023/24. This is in line with the English average. • 40% of adults in Cardiff and Vale of Glamorgan are a healthy weight, as compared to 36% of the Welsh average (NSfW, 2021/22+2022/23); 39% are eating five portions of fruit/vegetables a day, compared to 29% in Wales (NSfW, 2021/22+2022/23) and 66% are meeting physical activity guidelines of being active for at least 150 minutes per week, as compared to 56% in Wales (NSfW, 2021/22+2022/23)*. There are no comparable data in other UK countries due to different methodologies being used. • Differences remain between our most and least deprived communities with levels of healthy weight lower, and consumption of fruit and vegetables/physical activity levels also lower in the most deprived areas of Cardiff and Vale. **Weight management services** • L2 – 510 new patients capacity • L3 – 46 new patients capacity	2023/24 Q1 2025/26	**Healthy weight:** On target **Weight management services:** Below target	

<table>
<tr><th>Priority</th><th>Performance Summary</th><th>Reported Period</th><th>On target?</th><th>Data</th></tr>
<tr>
<td>Health improvement</td>
<td>
Diabetes
• Percentage of patients with diabetes with completed care processes
  • Static trend/very slight downward trend
  • Whilst overall completion rates is c. 46%, some processes (e.g. HbA1c check) are substantially higher percentage uptake compared to others (e.g. urine albumin) - some of this may be the way the data are collected rather than actual lack of care process completion. Working group being established with pan-cluster membership to review processes and share best practice on improving rates.

• Percentage of patients with diabetes with completed care processes – by each care process
  • Static/very slight downward trend
  • Whilst overall completion rates is c. 46%, some processes (e.g. HbA1c check) are substantially higher percentage uptake compared to others (e.g. urine albumin) - some of this may be the way the data are collected rather than actual lack of care process completion. Working group being established with pan-cluster membership to review processes and share best practice on improving rates.
</td>
<td>Aug 2025</td>
<td>Below target</td>
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<table>
<tr><th>April 2025</th><th>May 2025</th><th>Jun 2025</th><th>Jul 2025</th><th>Aug 2025</th></tr>
<tr><td>46.53%</td><td>45.93%</td><td>46.04%</td><td>46.06%</td><td>45.67%</td></tr>
</table>
<table>
<tr><th>Care process</th><th>April 2025</th><th>May 2025</th><th>June 2025</th><th>July 2025</th><th>Aug 2025</th></tr>
<tr><td>Urine ACR</td><td>63.14%</td><td>62.91%</td><td>62.9%</td><td>63.14%</td><td>63.1%</td></tr>
<tr><td>Foot check</td><td>70.28%</td><td>69.62%</td><td>69.84%</td><td>69.7%</td><td>69.42%</td></tr>
<tr><td>Smoking status</td><td>73.98%</td><td>72.9%</td><td>73.03%</td><td>72.56%</td><td>72.41%</td></tr>
<tr><td>BMI</td><td>78.91%</td><td>78.37%</td><td>78.57%</td><td>78.33%</td><td>78.3%</td></tr>
<tr><td>Serum cholesterol</td><td>80.63%</td><td>80.29%</td><td>80.4%</td><td>80.47%</td><td>80.36%</td></tr>
<tr><td>Blood pressure</td><td>86.8%</td><td>86.32%</td><td>86.46%</td><td>86.75%</td><td>86.76%</td></tr>
<tr><td>HbA1c</td><td>88.91%</td><td>88.63%</td><td>88.58%</td><td>88.55%</td><td>88.62%</td></tr>
<tr><td>Serum creatinine</td><td>88.8%</td><td>88.58%</td><td>88.69%</td><td>88.63%</td><td>88.74%</td></tr>
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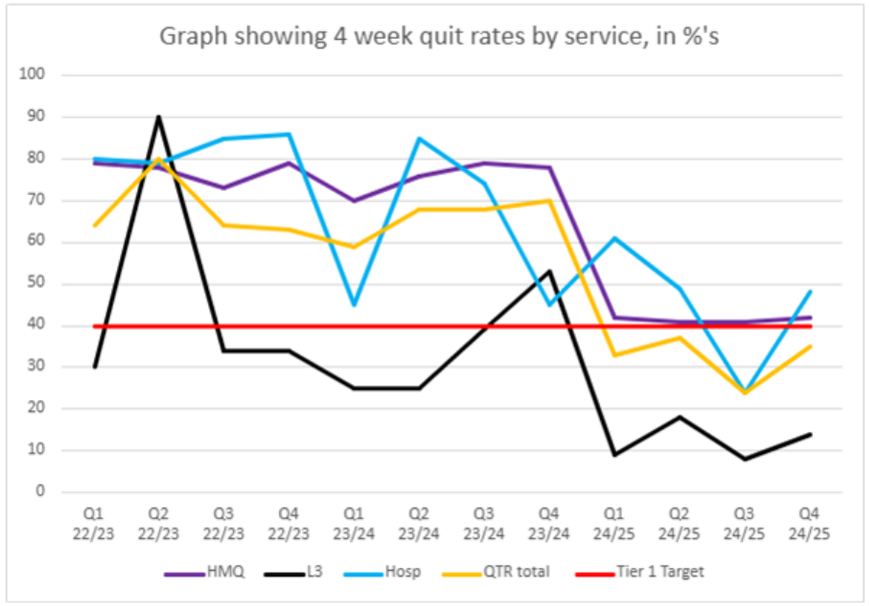
Priority	Performance Summary	Reported Period	On target?	Data
Health Improvement	**Tobacco** • **Latest data Q4 24/25** - 0.5% of smoking population made a quit attempt via smoking cessation service to become treated smokers. This is below the 0.8% local target. • The **Help Me Quit** (**HMQ) team** are delivering clinics across C&V with a focus on deprived communities where smoking rates are higher. Once clients are engaged with HMQ community services over 40% go on to become 4 week quitters. Links made with Pre op assessment team, Waiting Well service and Optometry to boost referrals. Ongoing work with maternity colleagues to increase % of pregnant smokers becoming treated smokers. • **Level 3 pharmacy** – the % of treated smokers that become 4 week quitters is 25%. This is below the target 40%. Awaiting a new all Wales SLA – this will inform future plans to boost activity. • **Hospital service** – linked to work to introduce enforcement of no smoking legislation on hospital premises. An online staff training module is now available and being promoted to staff to try to boost referrals. *We are waiting to receive data for Q1 2025/26.* *There is a time lag of around 6/8 weeks between a client's first interaction with a Smoking Cessation Adviser, and their progress showing in the data. This is due to the length of time between clients having an assessment session, setting a quit date, then progressing through their treatment plan, and reporting as having quit smoking for 4 weeks and this being validated by CO monitoring. Additional time is needed for data to be processed and presented.*	Q4 24/25	Below target	

Smoking

NHS Wales Performance Framework measures

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend			
1.	Percentage of adult smokers who make a quit attempt via smoking cessation services *Waiting for WG data for Q1* *186 treated smokers achieved by the Community HMQ service in C+V (doesn't include pharmacy or hospital service activity) in quarter 1 2025/26*	Q4 24/25	National target is 1.25% per quarter, 5% per year Local target 0.8% per quarter	0.5% (Q4 24/25) Below target	**Q1** 0.5% (Q4 24/25)	**Q2**	**Q3**	**Q4**
2.	Percentage of adult smokers who make a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks. *Waiting for WG data for Q1* *56% of treated smokers by the community services were 4week validated quitters in this quarter (doesn't include pharmacy or hospital service activity)*	Q4 24/25	40%	38% (Q4 24/25) Below target	**Q1** 38% (Q4 24/25)	**Q2**	**Q3**	**Q4**

Other measures

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend			
n/a	% of pregnant people undergoing CO testing at their initial booking appointment	Q1 25/26	100%	97% Q1 25/26 Below target	**Q1** 97%	**Q2**	**Q2**	**Q4**
n/a	% of pregnant smokers who are referred to smoking cessation support following initial booking assessment	Q1 25/26	100%	100% Q1 25/26 Meeting target	**Q1** 100%	**Q2**	**Q2**	**Q4**

Substance misuse

NHS Wales Performance Framework measures

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend			
3.	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs and alcohol)* *This measure includes people who have been referred to **health board services, health board commissioned services** (CAVDAS – Cardiff and Vale Drug and Alcohol Service) and **Dyfodol** (for people in contact with the criminal justice service) who live in the Cardiff and Vale area. The measure may also include other services outside Cardiff and Vale, but where the client resides in Cardiff and Vale.*	Q1 2025/26	4 quarter improvement trend		**Q1** 68.70%	**Q2**	**Q3**	**Q4**

**Note: As of August 2025, the methodology for this measure has changed and all previous data has been revised. This data now excludes neutral closures, such as: referred elsewhere, moved on, moved to GP prescribing and prison, as it is deemed that these individuals will still continue their treatment elsewhere.*

Other measures

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend			
n/a	Percentage of people who have been referred to **health board and health board commissioned services** who have completed treatment for substance misuse (drugs or alcohol). This measure includes health board and health board commissioned services (CAVDAS – Cardiff and Vale Drug and Alcohol Service).	Q1 2025/26	See performance measure 3, above		**Q1** 80.47%			
	Percentage of people who have been referred **to health board services** who have completed treatment for substance misuse (drugs or alcohol).	Q1 2025/26	See performance measure 3, above		95.52%			

Immunisation and vaccination

NHS Wales Performance Framework measures

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend			
4.	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	Jan-Mar 25	95%	84.6% Below target	**Jan-Mar**	**Apr-Jun**	**Jul-Sept**	**Oct-Dec**
					84.6%			
5.	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15 *Applicable during: 01.04.2025 - 30.06.2025 and 01.01.2026 - 31.03.2026*	1 Jan 25 – 30 Apr 25	90%	68.8% Below target	**Q1**	**Q2**	**Q3**	**Q4**
					68.8%			
6.	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over *Applicable during: 01.09.2025 - 31.03.2026*	n/a	75%					
7.	Percentage uptake of the COVID-19 vaccination for those eligible *Applicable during: Spring Booster 01.04.2025 - 30.06.2025 Autumn Booster 01.09.2025 - 31.03.2026*	At 8 Aug 25	75%	56.8% Below target	**29/5/25**	**10/07/25**	**5/8/25**	
					47.86%	56.66%	56.8%	

Weight Management Services

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend			
n/a	Increase L2 service capacity	Q1 25/26	n/a	Q1 – 510 new patients capacity	**Q1**	**Q2**	**Q3**	**Q4**
					510			
n/a	Increase L3 service capacity	Q1 25/26	n/a	Q1 – 46 new patients capacity	**Q1**	**Q2**	**Q3**	**Q4**
					46			

Diabetes

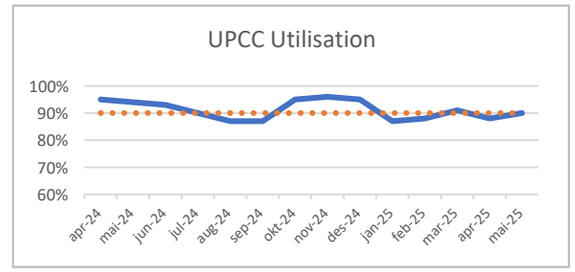
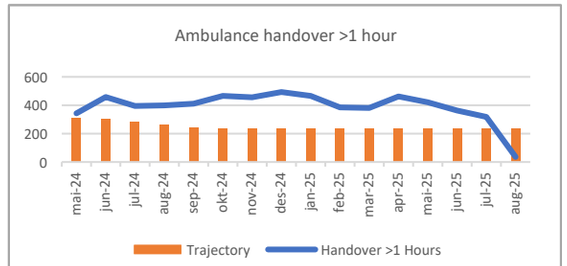
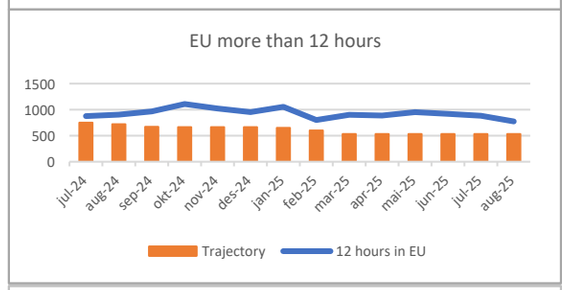
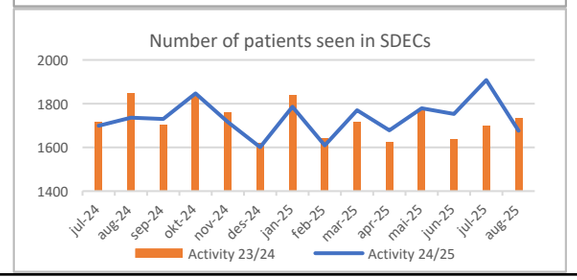
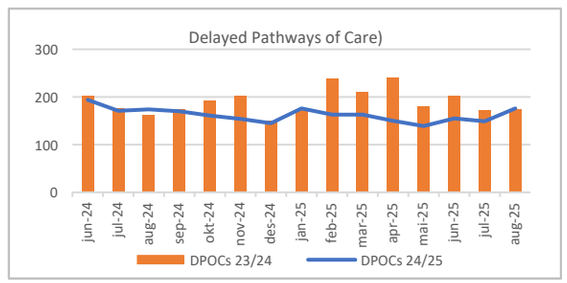
NHS Wales Performance Framework measure

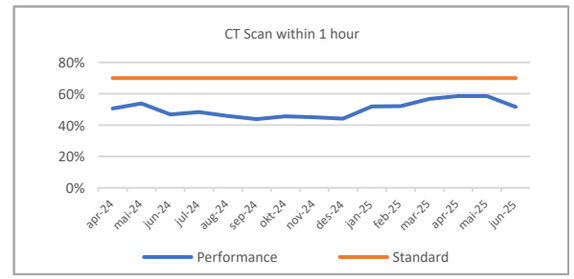
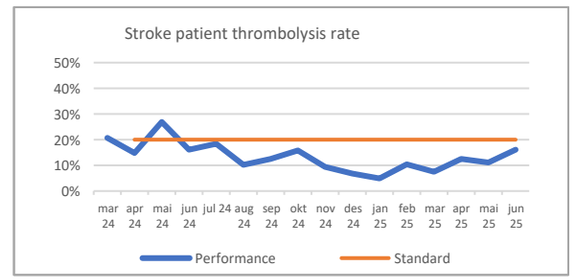
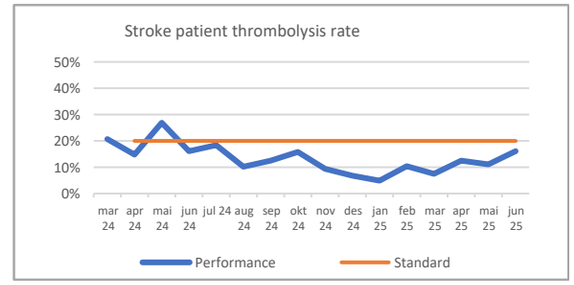
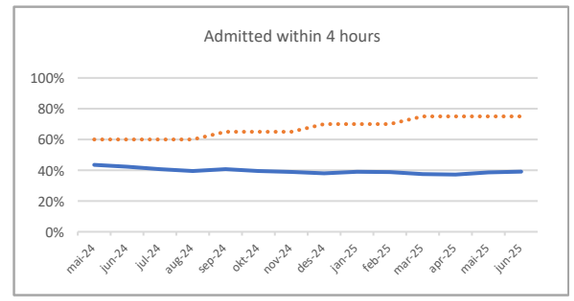
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
12.	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	See Quadruple Aim 2, measure no. 12			

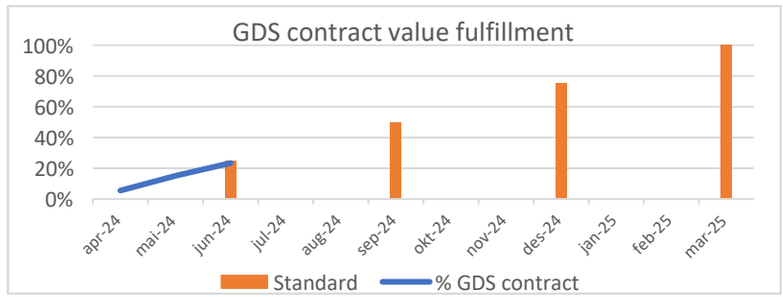
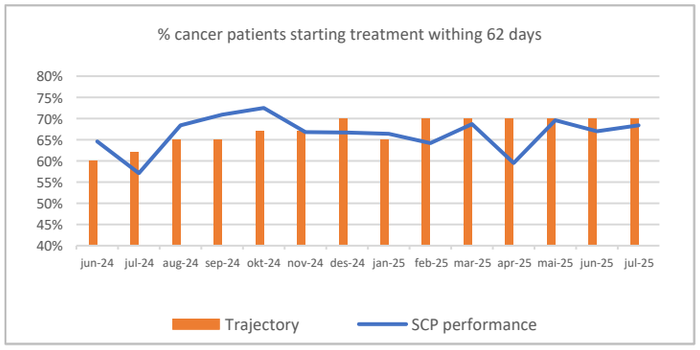
Screening

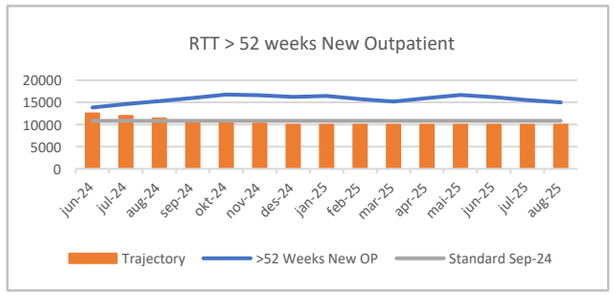
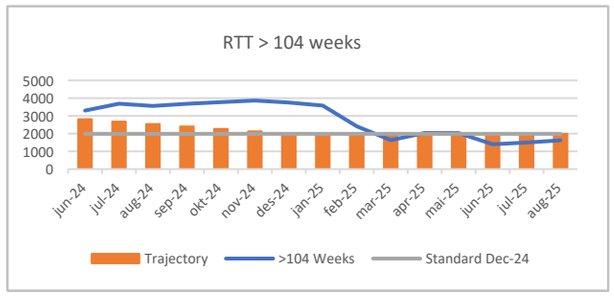
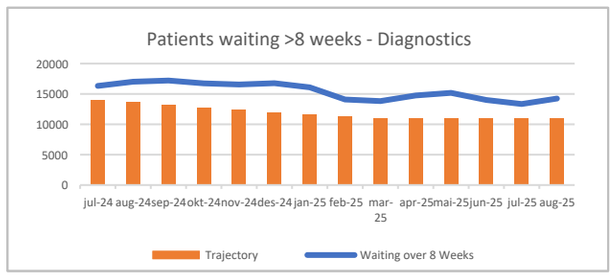
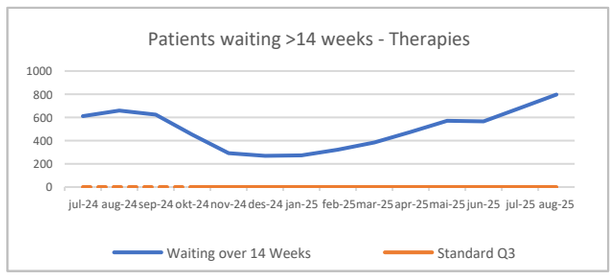
NHS Wales Performance Framework measures

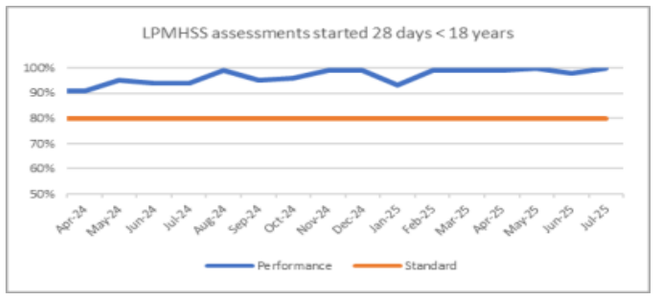
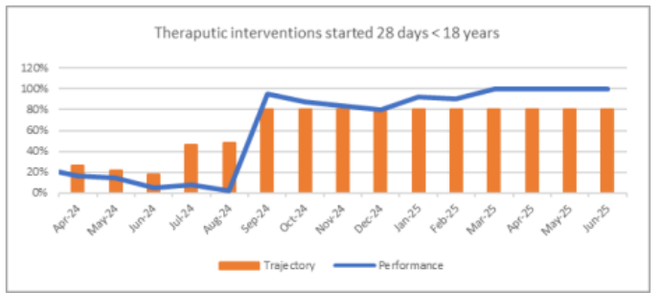
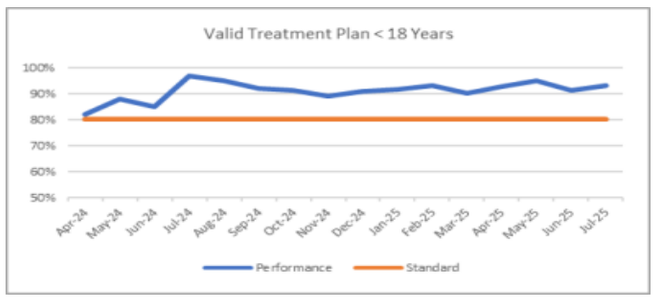
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
8.	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	Jun-25	90%	**3.2%** Below standard	Mar-25: 1.60%; Apr-25: 1.60%; May-25: 0.00%; Jun-25: 3.20%
9.	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	Jun-25	90%	**95.9%** Above standard	Mar-25: 97.80%; Apr-25: 97.30%; May-25: 98.70%; Jun-25: 95.90%
10.	Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life	Jul-25	95%	**98.3%** Above standard	Apr-25: 96.10%; May-25: 96.50%; Jun-25: 95.10%; Jul-25: 98.30%

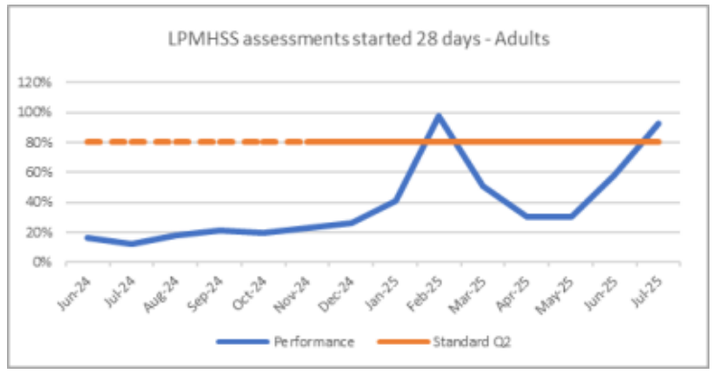
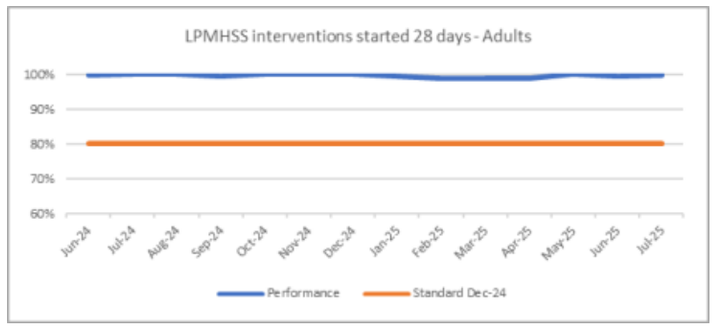
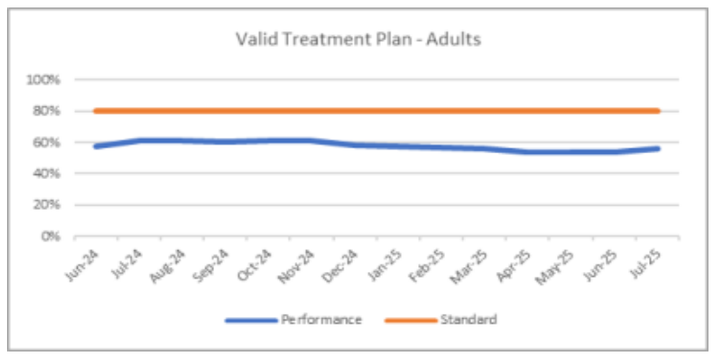
Priority	Performance Summary	Reporting Period	Performance against standard	Data
Primary, Community and Out of Hospital Care	**Urgent Primary Care Centre Utilisation – Maintain 90% utilisation** In August utilisation was 81%, this is below our commitment. We have made changes to the model, combining face to face consultations and use of the triage service within the reporting	Aug-25	81% utilisation Below standard	
	Community visits – 95% of face-to-face visits within 8 hours Q1 to date 94% compliance with 8-hour standard	Aug-25	94% Below standard	
Emergency Department and Same Day Emergency Care	**Ambulance handover delays – eliminate 2-hour delays. Reduce 1-hour delays to <365 per month from Q1, < 400 per month in Q4** In August we reported zero 2-hour ambulance delays, a reduction from June, and delivering our commitment to eliminate 2-hour delays. In August we reported 39 1-hour ambulance delays, a significant reduction from July and below our commitment of <365 In August lost minutes per arrival reduced further to 11, a significant improvement reflecting the reduced delays noted above	Aug-25	0 2-hour delays At standard 39 1-hour delays Below standard 11 minutes lost/arrival Above standard	
	ED waits - No patients waiting >24 hours in ED, <700 patients waiting <12 hours in ED per month in Q1 and Q4, <650 in Q2 and Q3 In August we reported a decrease in patients waiting 12-hours in EU compared to July. This equates to 93.2% of attendances waiting less than 12-hours and below our ambition for Q4	Aug-25	93.2% patients <12h Below standard	
	SDEC units In August we reported an decrease in activity compared to July, and below August 2024 activity. A drop in medical SDEC has been noted and the team have identified a potential underreporting of attendances which is being investigated – attendances are forecast to increase	Aug-25	1676 SDEC attends Below standard	
Reducing time in hospital and Continuity of Care	**Length of stay - <20% patients in acute beds to have a LOS >21 days, <40% patients in acute beds to have a LOS >7 days** This data is a monthly snapshot taken at on the final Friday of each month. At the end of August 56.9% of patients in acute beds had a LOS of >7 days, 34.9% >21 days – increased from July	Aug-25	58.4% >7d Above standard 34.9% >21d Above standard	
	Pathway of Care Delays – <160 delayed patients each month In August 2025 the number of POCDs was 176 – this is above the number of delays reported in July 2025. We continue to work internally and with LA partners to reduce the number of POCD	Aug-25	176 Above standard	

Priority	Performance Summary	Reporting Period	Performance against standard	Data
High Impact Pathways - Stroke	**CT scan – 70% of patients scanned within 1 hour of arrival at EU** In July 59.5% of patients were received their CT scan within 1 hour of arrival at EU, increased from June. **Thrombolysis – 20% thrombolysis rate** In July 10.8% of stroke patients were thrombolysed, We are clinically reviewing internally and working with colleagues from NHS Executive **Admission – 80 % of patients admitted directly to the stroke unit within 4 hours** In July 62.9% of patients were admitted directly to the Stroke Unit within 4 hours. Door-to-ward pathways continue to be impacted by operational pressures within the Emergency Unit Our door-to-ward and CT Stoke performance measures are below our ambitions for performance on the stroke pathway. We have seen considerable improvements compared to last year – a business case for development of the service has been approved and will allow more sustainable improvements to be embedded Overall Stroke performance is assessed through the Sentinel Stroke National Audit Programme (SSNAP) – which uses metrics across the whole patient pathway. In the most recent assessment period UHW received a grade B. The SSNAP criteria have changed for this year and will be reflected in the 25/26 IPR following conclusion of National discussions around KPIs for Wales	Jul-25	59.5% CT Below standard 10.8% Thrombolysis Below standard 62.5% Door-to-ward Below standard	  
High Impact pathways – Hip fracture	**Hip Fracture** Door to Ward time is the first KPI used by the National Hip Fracture Database to monitor national performance across the patient pathway. In June our annualised compliance showed 39.1% of patients were admitted to the ward within 4 hours. This is below our ambition but well above the national average of 9.2%.	Jun-25	39.1% (Annualised) Below standard	

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Primary and Community Care	**GMS access – 100% of practices achieving core access standards** In April 100% of practices met the standard – the official data is provided annually but our monthly tracking data will be updated here for information **GDS access – 25% of contract value by end Q1, 50% Q2, 75% Q3, 100% Q4** At the end of March 98.5% of the contract value had been delivered. So far in 25/26 (data to June) 23.5% of the contract value has been delivered **Pharmacy access – >2185 accessing Pharmacy Independent Prescriber service** In June 100% of practices were providing CCPS services, providing 2398 consultations **Optometry – 95% of practices providing WGOS1+2** All practices are currently providing WGOS 1&2	Apr-25 Jun-25	100% At standard 23.5% Below standard (Apr-25 – Jun 25) 2,398 Above standard 100% Above standard	
Cancer	**Single Cancer Pathway – 75% of patients to receive their first definitive treatment within 62 days by Q4** In July 68.4% of patients received their first definitive treatment within 62 days. This is below our ambition. In recent months we have seen the number of patients waiting >62 days for treatment increase and performance is challenged as a result of treating the longest waiting patients in month.	Jul-25	68.4% Below standard	

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Outpatient and Treatment waiting times	**Outpatient waiting times – Reduction in the number of patients waiting 52 weeks for a first outpatient appointment** In August there were 14,990 patients waiting 52 weeks for their first outpatient appointment. This is improved from July, additional actions are outlined in the cover paper **Treatment waiting times – Reduction in the number of patients waiting 104 weeks for treatment** In August there were 1,622 patients waiting 104 weeks for treatment. This is an increase from July but in line with the trajectory shared with Welsh Government. We are working to deliver a reduction by the end of Q2 and will work with Welsh Government to continue to improve the position through the year	Aug-25	14,990 patients Above standard 1,622 patients Above standard (Q2)	 
Diagnostics and Therapies Saunders Nathan 21/09/2025 15:54:19	**Diagnostics – Reduction in the number of patients waiting over 8 weeks for a specified diagnostic** In August 14,243 patients were waiting over 8 weeks for a specified diagnostic, A increase from July, Improvement in the radiology position this month, with NOUS waits notably reduced. **Therapies – National standard of zero 14 week waits** In August 797 patients were waiting over 14 weeks for therapies, An increase from July. Breaches are concentrated in OT, Dietetics and Physiotherapy and team are working to bring the specific services back into balance. Physiotherapy has seen a significant reduction in waits since Q3 24/25	Aug-25	14,243 patients Diagnostics Above standard 797 patients Therapies Above standard	 

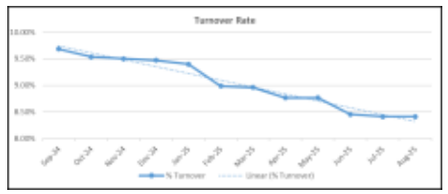
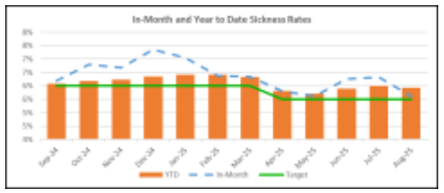
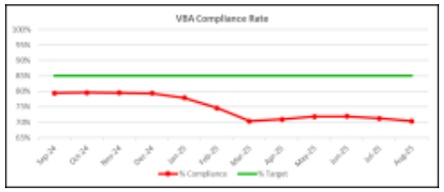
Priority	Performance Summary	Reporting Period	Performance against standard	Data
Paediatric waiting times	**New Outpatient waits – 0 patients waiting over 52 weeks for outpatients in Q1** In August there were 0 patients waiting over 52 weeks for a new outpatient appointment	Aug-25	0 Meeting standard	
Emotional Health and Wellbeing	**Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for under 18s – 80% compliance with the Standard of <28 days** In July 100% of assessments were completed within 28 days		98% Part 1a Above standard	
	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for under 18s – 80% compliance with standard In July 100% of interventions were started within 28 days, this is above the standard for Q3 and in line with the forecasts for the early part of this year	Jul-25	100% Part 1b Above standard	
	Percentage of patients with a valid Care and Treatment plan – 80% compliance with standard In July 93% of patients had a valid Care and Treatment Plan, above our ambition		93% Part 2 Above standard	

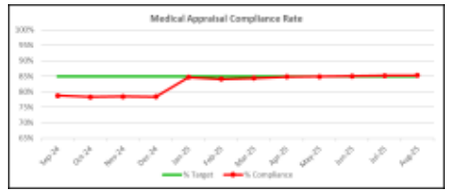
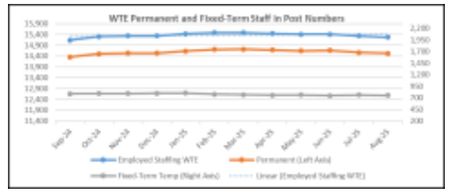
Priority	Performance Summary	Reporting Period	Performance against standard	Data
Mental Health Measures – Part 1a	**Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over – 80% compliance with the Standard of <28 days** In July 92% of patients received their assessment within 28 days. Referrals to the service remain high.	Jul-25	92.4% Part 1a Above standard	
Mental Health Measures – Part 1b	**Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for adults – 80% compliance with standard** In July 99.8% of therapeutic interventions were started within 28 days of assessment, above the standard and in line with our trajectory submitted to Welsh Government.	Jul-25	99.8% Part 1b Above standard	
Mental Health Measures – Part 2	**Percentage of patients with a valid Care and Treatment plan – 80% compliance with standard** In July 56.2% of patients had a valid Care and Treatment plan, a small decrease from April following focused work from the teams. Performance remains below the standard– the RAMP protocol and Part 1 schemes have been approved though the Mental Health Liaison Committee to support longer term improvements in compliance	Jul-25	56.2% Part 2 Below standard	

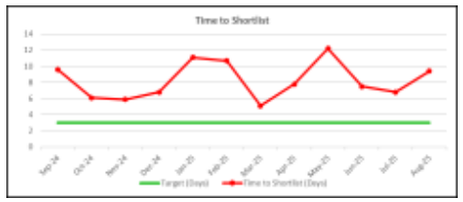
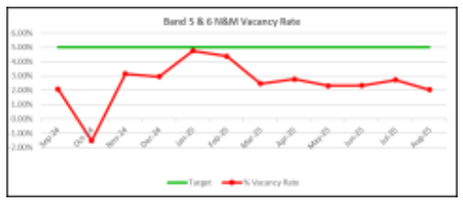
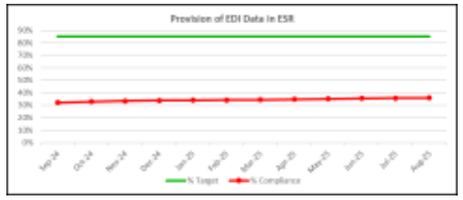
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
11.	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	2023/24	100%	**100%** At standard	19/20: 93.4% | 20/21: 95.0% | 21/22: 96.5% | 22/23: 98.2%
12.	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Jun-25	Improvement compared to the same month in the previous year	**46.1%** Above standard	Mar-25: 46.30% | Apr-25: 46.50% | May-25: 45.90% | Jun-25: 46.10%
13.	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Apr-25 to Jun-25	A month on month increase towards a minimum of 30% contract value delivered by 30 September 2024 and 100% by 31 March 2025	**23.4%** Above standard	Apr-25: 5.50% | Apr25 - May-25: 15.10% | Apr-25 - Jun-25: 23.40%
14.	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Jun-25	Increase compared to the same month in the previous year	**2,398** Above standard	Mar-25: 2465 | Apr-25: 2516 | May-25: 2388 | Jun-25: 2398
15.	Percentage of Local Primary Mental Health Support Service (LMPHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged under 18 years	Jul-25	80%	**99%** Above standard	Apr-25: 99% | May-25: 100% | Jun-25: 98% | Jul-25: 99%
16.	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for people aged under 18 years	Jul-25	80%	**96%** Above standard	Apr-25: 100% | May-25: 100% | Jun-25: 100% | Jul-25: 96%
17.	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over	Jul-25	80%	**92.0%** Above standard	Apr-25: 30.0% | May-25: 30.0% | Jun-25: 57.9% | Jul-25: 92.0%
18.	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for adults aged 18 years and over	Jul-25	80%	**99.6%** Above standard	Apr-25: 100.0% | May-25: 100.0% | Jun-25: 99.5% | Jul-25: 99.6%
19	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	Jun-25	65%	**50%** Below standard	Mar-25: 50% | Apr-25: 51% | May-25: 50% | Jun-25: 50%
20.	Median emergency response time to amber calls	Jun-25	12 month reduction trend	**01:34:20** Above standard	Mar-25: 01:46:41 | Apr-25: 01:58:55 | May-25: 01:19:34 | Jun-25: 01:34:20

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
21.	Median time from arrival at an emergency department to triage by a clinician	Jun-25	15 minutes or less	**6** Below standard	Mar-25: 8; Apr-25: 8; May-25: 6; Jun-25: 6
22.	Median time from arrival at an emergency department to assessment by a clinical decision maker	Jun-25	60 minutes or less	**68** Above standard	Mar-25: 64; Apr-25: 63; May-25: 64; Jun-25: 68
23.	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	Aug-25	Improvement compared to the same month in the previous year, towards the national target of 95%	**61.5%** Below standard	May-25: 63.9%; Jun-25: 61.3%; Jul-25: 65.5%; Aug-25: 61.5%
24.	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer, or discharge	Aug-25	Reduction compared to the same month in the previous year, towards the national target of zero	**774** Above standard	May-25: 952; Jun-25: 919; Jul-25: 883; Aug-25: 774
25.	Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Jul-25	12 month improvement trend towards a national target of 80% by 31 March 2026	**68.4%** Below standard	Apr-25: 59.5%; May-25: 69.6%; Jun-25: 67.0%; Jul-25: 68.4%
26.	Number of patients waiting more than 8 weeks for a specified diagnostic	Aug-25	0	**14,243** Above standard	May-25: 15177; Jun-25: 14007; Jul-25: 13344; Aug-25: 14243
27.	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional therapy	Mar-25	100%	**72%** Below standard	Dec-24: 86.24%; Jan-25: 82.00%; Feb-25: 76.66%; Mar-25: 71.58%
28.	Number of patients (all ages) waiting more than 14 weeks for a specified therapy	Aug-25	0	**797** Above standard	May-25: 571; Jun-25: 566; Jul-25: 681; Aug-25: 797
29.	Number of patients (all ages) waiting more than 14 weeks for audiology	Jul-25	0	**861** Above standard	Apr-25: 294; May-25: 456; Jun-25: 679; Jul-25: 861

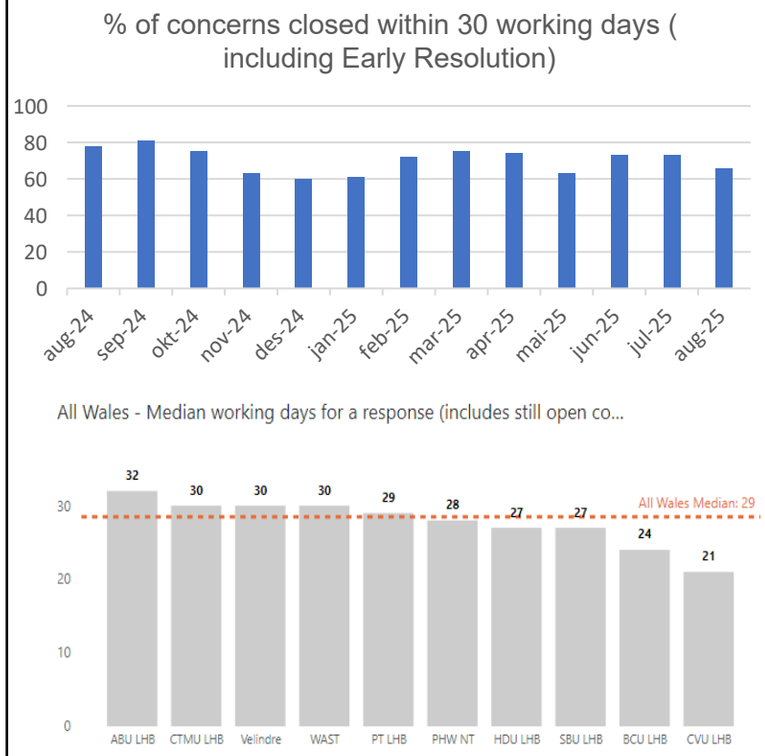
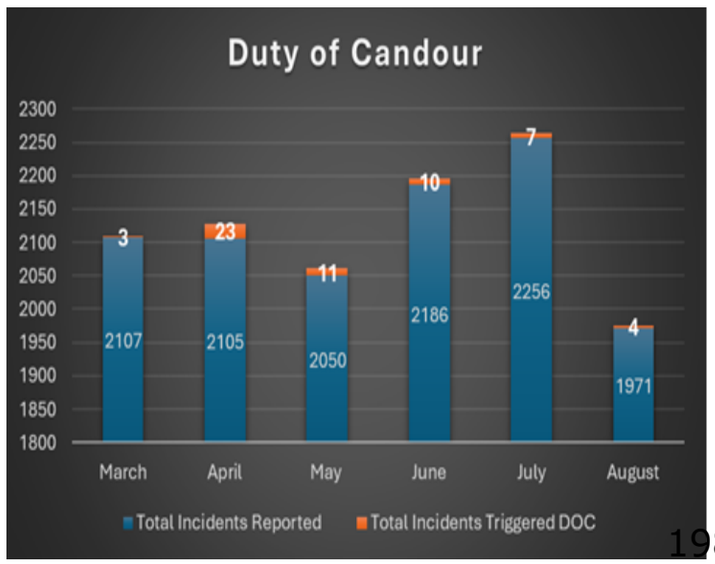
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
30.	Number of patients waiting more than 52 weeks for a new outpatient appointment	Aug-25	0	**14,990** Above standard	May-25: 16663; Jun-25: 16172; Jul-25: 15505; Aug-25: 14990
31.	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Aug-25	Reduction compared to the same month in the previous year	**24,346** Below standard	May-25: 22853; Jun-25: 22503; Jul-25: 23,473; Aug-25: 24,346
32.	Number of patients waiting more than 104 weeks for referral to treatment	Aug-25	0	**1,623** Below standard	May-25: 2030; Jun-25: 1401; Jul-25: 1498; Aug-25: 1623
33.	Number of patients waiting more than 52 weeks for referral to treatment	Aug-25	Month on month reduction towards the national target of zero by 30 June 2025	**32,990** Above standard	May-25: 35620; Jun-25: 34374; Jul-25: 33323; Aug-25: 32990
34.	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	Jul-25	80%	**19%** Below standard	Apr-25: 14%; May-25: 13%; Jun-25: 16%; Jul-25: 19%
35.	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Jul-25	80%	**68%** Below standard	Apr-25: 77%; May-25: 77%; Jun-25: 68%; Jul-25: 68%

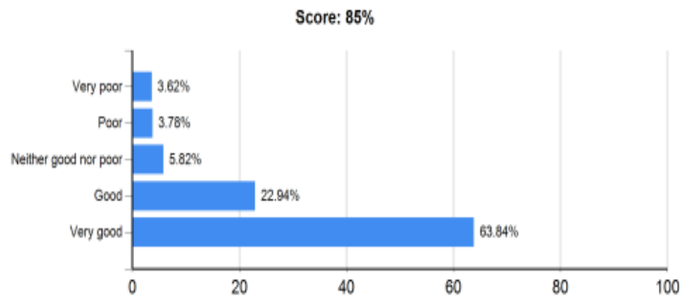
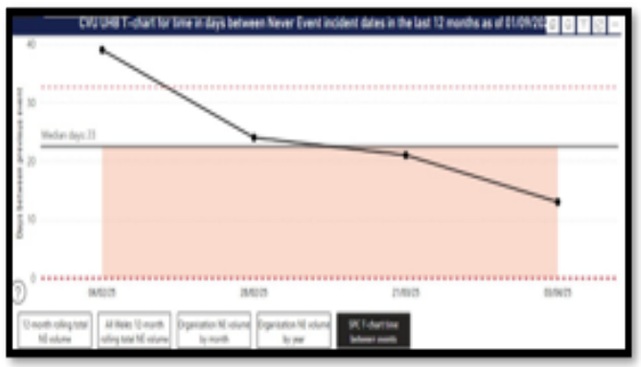
Priority	Performance Summary	Reported Period	Data
Turnover	The overall trend is downwards since Sep-24; the rates have fallen from 9.68% at Sep-24 to 8.41% in Aug-25 UHB wide. This is a net 1.27% decrease, which represents 180 WTE fewer leavers. The top 5 reasons recorded for leaving are; 'Voluntary Resignation - Other/Not Known', 'Retirement Age', 'Voluntary Resignation – Relocation', 'Voluntary Resignation – Promotion' and 'Voluntary Resignation - Work Life Balance'.	August 2025	
Sickness Absence	The monthly sickness rate for Aug-25 was 5.62%. The 12-month cumulative rate has risen slightly during the past year and is 6.37% at Aug-25 (an increase of 0.12% by comparison with the rate at Jul-24).	August 2025	
Statutory and Mandatory Training	The overall compliance rates fell for Aug-25 to 82.54%, 2.46% below the overall target. The compliance for Capital, Estates & Facilities, All Wales Genomics Service and Corporate Executives are above the 85% target; and Clinical Diagnostics & Therapeutics, Children & Women's, PCIC and Specialist Services are above 80% compliance. The compliance with Fire training has fallen to 71.85% at Aug-25 . Other than for All Wales Genomics Service the compliance for all of the Clinical Boards is below the 85% compliance target.	August 2025	 
Values Based Appraisal	VBA compliance has fallen again for Aug-25, to 70.35%. Capital, Estates & Facilities is the only Clinical Board that has achieved the 85% target rate%.	August 2025	
Employee Relations	As can be seen in the graph the number of employee relations cases the People Services team are supporting has risen in the past 12 months and the number of disciplinary cases remains above the UHB Target. The People Services Team continue to analyse trends of employee relations cases to develop bespoke training packages or additional toolkits/support services where appropriate.	August 2025	

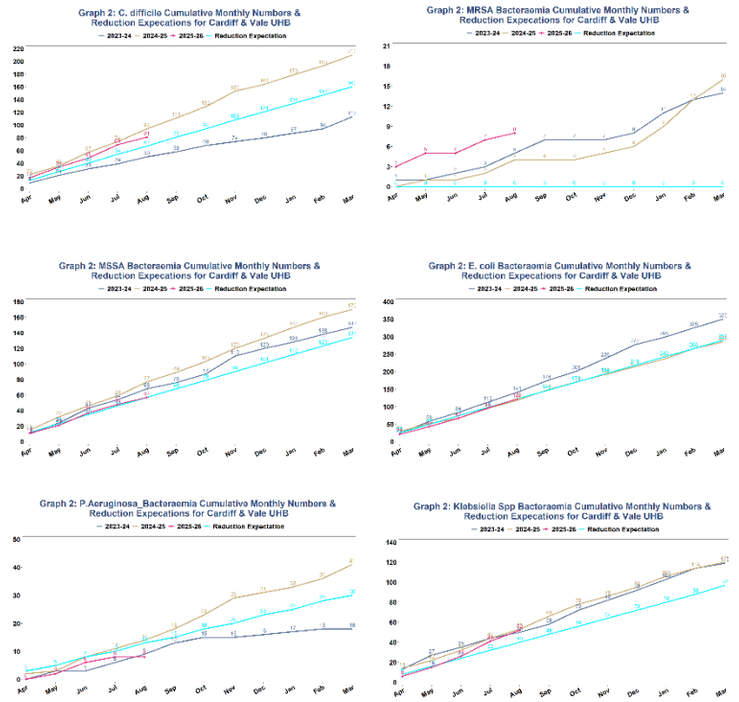
Priority	Performance Summary	Reported Period	Data
Job Plans	The vast majority of clinicians have now engaged with job planning and have a job plan in the system. 76.33% have a signed off job plan, against a target of 90% to be achieved by Sep-25.	August 2025	
Medical Appraisals	The rate of compliance with Medical Appraisal rose slightly to 85.23% for Aug-25, and remains just above the 85% target.	August 2025	
Staff in Post	The overall Health Board Staffing Numbers have increased in the last 12 months by 135 WTE, to 15,278.51 WTE at Aug-25. There has however been a reduction of 211 WTE since Feb-25, which has been achieved through the implementation of a vacancy freeze from Jan-25. The vacancy freeze will continue until Mar-26, with the intention to further reduce staffing levels.	August 2025	
Variable Pay (Bank, Agency, Overtime..)	The trend of proportion of the pay bill spend on variable pay (Bank, Agency, overtime etc.) continues to fall. At Sep-24 the percentage was 7.98% of the total spend on pay, but in Aug-25 had fallen to 6.16%. It must however be borne in mind that the total pay bill is increasing. There was no notable reduction in the quantity of variable pay in Nov-24, the dip on the chart is as a consequence of the total pay bill including payment of pay award and arrears.	August 2025	
Staff Winter Vaccination Programme	By the end of Mar-25 35.28% of staff have received the flu vaccine, and 28.29% of staff have received the COVID-19 vaccine. The winter flu vaccination programme for 2025-26 commenced in Sep-25; it is expected that uptake data will be included in the next report.		
Agency Spend as % of Total Pay Bill	The proportion of the total pay bill attributed to Agency for Sep-24 was 0.57% of the total spend on pay and was 0.39% at Aug-25. The percentage has however risen since Mar-25. It must also be borne in mind that the total pay bill is increasing.	August 2025	

Priority	Performance Summary	Reported Period	Data
Time to Hire	The All-Wales target for recruitment Time to Hire (the time interval between vacancy creation and successful candidate ready for start date) is 71 days, and the NHS Wales monthly average is 62.1 days. The figure for Cardiff & Vale uHB for Aug-25 was 103.9 days. This change is due to the vacancy freeze implemented in Jan-25, which will continue until Mar-26.	August 2025	
Time to Shortlist	The All-Wales target for recruitment Time to Shortlist (the time interval between vacancy closure and shortlisting completion) is 3 days, and the NHS Wales average is 6.6 days. The figure for Cardiff & Vale uHB for Aug-25 was 9.4 days.	August 2025	
Exit Questionnaire Completion	At Jun-25 the return rate of exit questionnaires was 21%, against a target of 30%. The returns rate will be produced quarterly; the next update will be for Sep-25.	June 2025	
Nursing & Midwifery Band 5 & 6 Vacancy Rates	The vacancy rate is the difference between the funded establishment WTE and the sum of the staff in post WTE represented as a percentage of the funded establishment WTE. At Aug-25 the rate was 2.04%, by comparison with a nominal 5% target. The swing between Oct-24 and Nov-24 was significantly impacted by validation of ESR position data.	August 2025	
Provision of EDI Data in ESR	This measure shows the percentage of staff who have recorded all of their Marital Status, Nationality, Ethnicity, Disability, Sexual Orientation, Religion and Country of Birth in ESR. At Aug-25 35.99% have recorded all of their EDI data. Country of Birth has the poorest compliance rate.	August 2025	
Percentage of Staff with Welsh Skills Levels 2 – 5 Recorded in ESR	This measure shows the percentage of staff who have recorded their Welsh Skills in ESR at level 2 (Foundation) through to level 5 (Proficient). 46.81% of staff have not recorded their Welsh Skills in ESR, and a range of activities are being undertaken to improve this. At Aug-25 6.57% of staff have identified their Welsh Skills as between level 2 and level 5.	August 2025	

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
36.	Percentage of sickness absence rate of staff	Aug-25	12 month reduction trend (5.50%)	**5.62%** Below standard	May-25: 5.59%; Jun-25: 6.22%; Jul-25: 5.90%; Aug-25: 5.62%
37.	Turnover rate for nurse and midwifery registered staff leaving NHS Wales	Aug-25	Rolling 12 month reduction against a baseline of 2019-20 (7-9%)	**8.41%** Above standard	May-25: 8.76%; Jun-25: 8.45%; Jul-25: 8.41%; Aug-25: 8.41%
38.	Agency spend as a percentage of the total pay bill	Aug-25	12 month reduction trend	**0.39%** Below standard	May-25: 0.39%; Jun-25: 0.41%; Jul-25: 0.79%; Aug-25: 0.39%
39.	Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (excluding doctors and dentists in training)	Aug-25	85%	**71.26%** Below standard	May-25: 72.59%; Jun-25: 72.68%; Jul-25: 72.04%; Aug-25: 71.26%

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Concerns 30-day performance	**Welsh Government target for responding to concerns is 75% within 30 working days** **During July and August 25, the Health Board:** •Received 572 Concerns •Closed 514concerns • 69 % closed within 30 working days (including Early Resolution) • 18 % closed under Early Resolution (within 2 days including day of receipt) •In addition •Received 656 Enquiries •Received 111 Compliments •We currently have 339 active concerns •Graph opposite shows median response time to formal concerns across Wales **Top 3 themes and trends** • Clinical Treatment and Assessment • Concerns around appointments (waiting times/cancellations) • Communication	July and Aug 25		
Duty of Candour	**Key Updates:** **From 1st March 2025 to 30th August 2025, a total of 12,675 incidents have been reported. Of these incidents, 6 have triggered the duty of candour.** **Themes and Trends for Triggered Duty of Candour:** · Avoidable pressure damage. · Avoidable falls. · Patients lost to follow-up. · Failure to prescribe or administer appropriate medication. · Administration of incorrect medication. · Missed opportunities to diagnose	*To August 30th 2025*		

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Patient Feedback – Civica	The system became operational on **Friday, 28 October 2022**. We are currently administering surveys to up to **1,000 patients per day** via text message. Of these, **600 patients** are randomly selected from general hospital activity, **200** from Emergency Unit (EU) activity, and **200** from Mental Health services. Over the past 12 months, more than **178,000 text messages** have been distributed, yielding an overall **response rate of 16%**. In **August**, a total of **15,141 messages** were sent, resulting in **2,701 completed surveys**, which corresponds to a **response rate of 18%**. Among respondents discharged in **July and August** who answered the rating question, **85% reported satisfaction** with the service received (refer to the chart opposite for further detail). While our current overall response rate of **16%** exceeds that of many comparable organisations, we remain committed to enhancing engagement and will prioritise improvements in this area over the coming year.	Jul/Aug 2025		
Patient Safety	The UHB Nationally Reportable Incidents (NRI) reporting rate in August 2025 was 2.31 per 100,000 population. Thirteen NRIs were reported in total during August 2025. There were 2335 patient safety incidents reported in August 2025 of which 390 were reported as resulting in moderate harm or above of these 63% have not been subject to an interim review by the first week in September. This is significant as initial reported harm is generally over estimated and 75% of those incidents initially recorded as resulting in moderate harm and above that have been subject to a review have been downgraded to no or low harm. However, 25% have been confirmed as having resulted in moderate harm or above and are therefore subject to the Duty of Candour and where deemed to have resulted in serious harm will require NRI reporting. All patient safety incidents should be subject to a timely review and robust fact finding and action to mitigate any risk.	August 25		 

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Tier 1 Mortality	The all-cause mortality rate across the Cardiff and Vale UHB area continues a similar seasonal pattern to the five-year average. Numbers of deaths are similar to the same period in the previous year. During week 31 of 2025, 94 deaths were registered in the CAV area, compared with 91 deaths registered during week 31 in 2024.	August 2025		 
Infection Control	*Clostridiodes difficile* – The total number of CDI cases this year is currently 80, with 26 hospital onset. This number of cases is 28 hospital onset cases lower than this period in 2024/2025. CAV UHB have the 2nd lowest rate of the 6 acute Health Boards in Wales. MRSA - The total number of MRSA cases this year is currently 7, with 4 hospital onset. This number of cases is 1 hospital onset case higher than this period in 2024/2025. CAV UHB have the 2nd highest rate of the 6 acute Health Boards in Wales. MSSA - The total number of MSSA cases this year is currently 57, with 22 hospital onset. This number of cases is 10 hospital onset cases lower than this period in 2024/2025. CAV UHB have the 3rd lowest rate of the 6 acute Health Boards in Wales. E.coli - The total number of E.coli cases this year is currently 122, with 28 hospital onset. This number of cases is 8 hospital onset cases lower than this period in 2024/2025. CAV UHB have the lowest rate of the 6 acute Health Boards in Wales. *Klebsiella spec's* - The total number of Klebs cases this year is currently 52, with 26 hospital onset. This number of cases is 7 hospital onset cases higher than this period in 2024/2025. CAV UHB have the 3rd lowest rate of the 6 acute Health Boards in Wales. PAER - The total number of Pseud cases this year is currently 9, with 6 hospital onset. This number of cases is the same as this period in 2024/2025. CAV UHB have joint 2nd lowest rate of the 6 acute Health Boards in Wales.	August 25		

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
40.	Percentage of episodes clinically coded within one reporting month post episode discharge end date	May-25	12 month improvement trend	**36.2%** Below standard	Feb-25: 42.30% | Mar-25: 43.50% | Apr-25: 49.80% | May-25: 36.20%
41.	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	Jun-25	90%	**54.4%** Below standard	Mar-25: 34.70% | Apr-25: 51.40% | May-25: 28.40% | Jun-25: 54.40%
42.	Percentage of calls ended following WAST telephone assessment (Hear and Treat)	Apr-24	17% or more	**16.1%** Below standard	Jan-24: 17.00% | Feb-24: 15.30% | Mar-24: 15.00% | Apr-24: 16.10%
43.	Number of Pathways of Care delayed discharges	Aug-25	12 month reduction trend	**176** Above standard	May-25: 139 | Jun-25: 155 | Jul-25: 149 | Aug-25: 176
44.	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for people aged under 18 years	Jul-25	90%	**93.3%** Above standard	Apr-25: 92.7% | May-25: 94.8% | Jun-25: 91.3% | Jul-25: 93.3%
45.	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for adults 18 years and over	Jul-25	90%	**53.8%** Below standard	Apr-25: 53.5% | May-25: 53.8% | Jun-25: 53.9% | Jul-25: 53.8%
46.	Number of service user feedback experience responses completed and recorded on CIVICA,figures lower for this period due to system failure.	Jul/Aug 25	(Some system issues)	↑ **6733**	In July and August we sent 31,442 texts

No.Reducing trend	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
47.	Cumulative number of laboratory confirmed bacteraemia cases: *Klebsiella* sp and; *Pseudomonas aeruginosa*	Aug-25	*Klebsiella sp* - 100 *P. aeruginosa* – 31	**52** **9** Below standard	Not on trajectory to achieve the reduction expectation number On trajectory to achieve the reduction expectation number
48.	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: *E.coli* and; *S.aureus* (MRSA and MSSA)	Aug-25	*E. coli* – 67 cases per 100,000 population *S. aureus* – 20 cases per 100,000 population	**56.16 cases per 100,000 population** Below Standard **29.46 cases per 100,000 population** Above standard	On trajectory to achieve the reduction expectation rate Not on trajectory to achieve the reduction expectation rate
49.	Cumulative rate of laboratory confirmed *C.difficile* cases per 100,000 population	Aug-25	25 cases per 100,000 population	**36.82 cases per 100,000 population** Above standard	Not on trajectory to achieve the reduction expectation rate
50.	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset (>14 days after admission)	Jul-25	Reduction compared to the same month in the previous year	**39.7%** On standard	Apr-25: 52.50%; May-25: 22.00%; Jun-25: 30.60%; Jul-25: 39.70%
51.	Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	Jun-25	12 month improvement trend towards national target of 95%	**64.80%** Below standard	Mar-25: 67.50%; Apr-25: 71.50%; May-25: 71.90%; Jun-25: 64.80%
52	Number of ambulance patient handovers over one hour	Aug-25	0	**36** Under standard	May-25: 421; Jun-25: 363; Jul-25: 318; Aug-25: 36
53.	Percentage of ambulance patient handovers within 15 minutes	Aug-25	Improvement compared to the same month in the previous year, towards the national target of 100% within 15 minutes	**18.08%** Below standard	May-25: 11.38%; Jun-25: 12.14%; Jul-25: 11.78%; Aug-25: 18.08%
54.	Number of National Reportable incidents that remain open 90 days or more				No longer reported by NHS P&I

Shaping Our Future
Digital
Services

Digital & Health Intelligence

Shaping Our Future
Digital Services

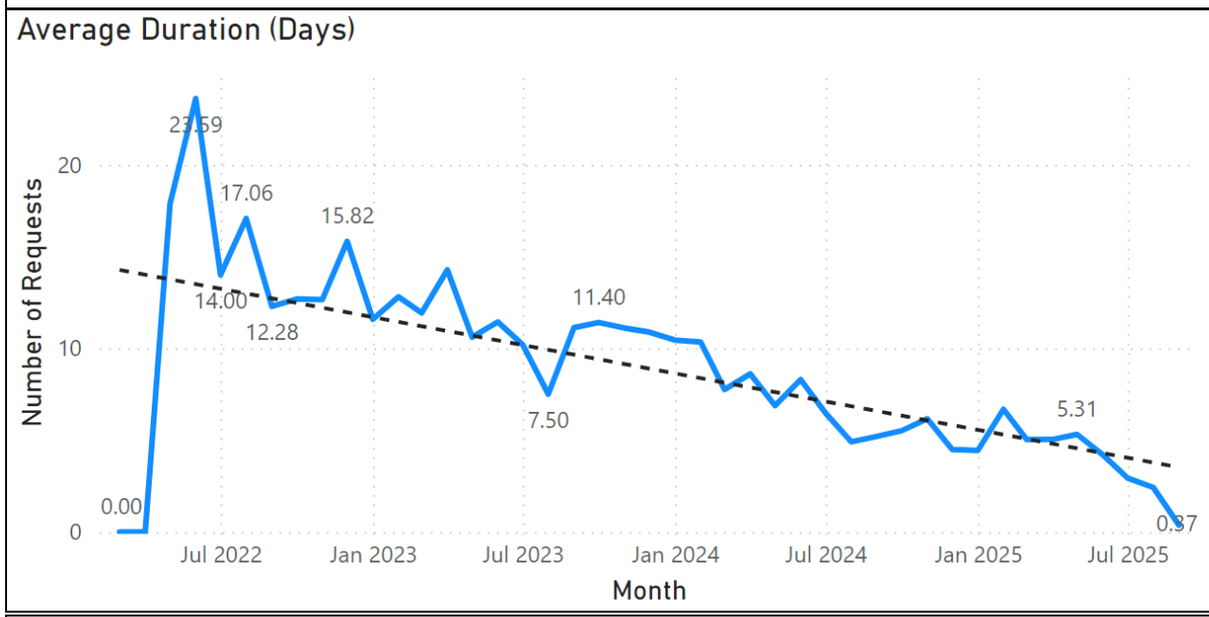
Executive Scorecard

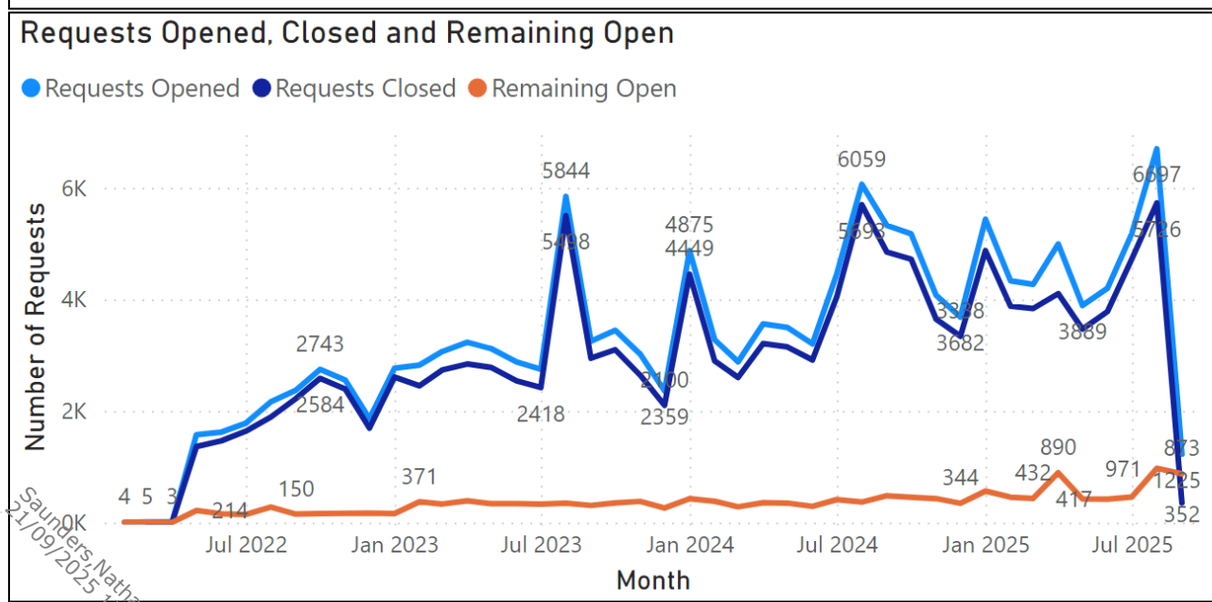
Year 2024		Current Year		Current Month	
Incidents	**Requests**	**Incidents**	**Requests**	**Incidents**	**Requests**
39321 Incidents Opened	50046 Requests Opened	25946 Incidents Opened	40210 Requests Opened	721 Incidents Opened	1225 Requests Opened
38930 Incidents Closed	45488 Closed Requests	24958 Incidents Closed	34731 Closed Requests	545 Incidents Closed	352 Closed Requests
391 Remaining Open	4558 Remaining Open	988 Remaining Open	5479 Remaining Open	176 Remaining Open	873 Remaining Open
4.83 Avg Duration (Days)	6.84 Avg Duration (Days)	4.00 Avg Duration (Days)	4.29 Avg Duration (Days)	0.22 Avg Duration (Days)	0.37 Avg Duration (Days)

Shaping Our Future
Digital Services

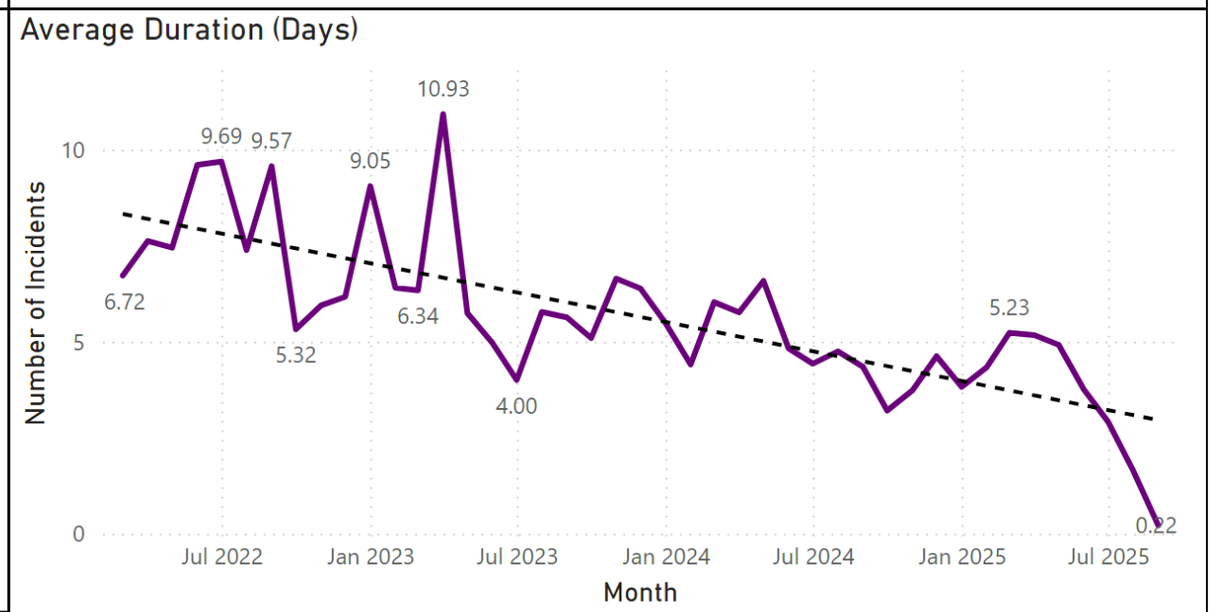
Executive Trending

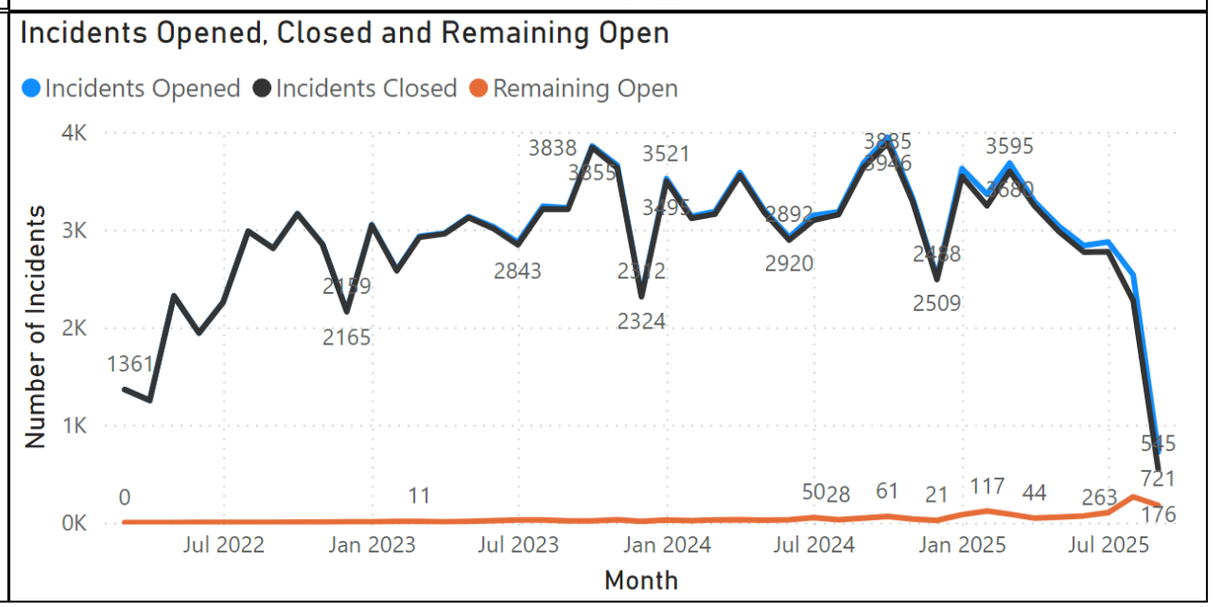
Requests (new and additional items)





Incidents (something that was working no longer works)





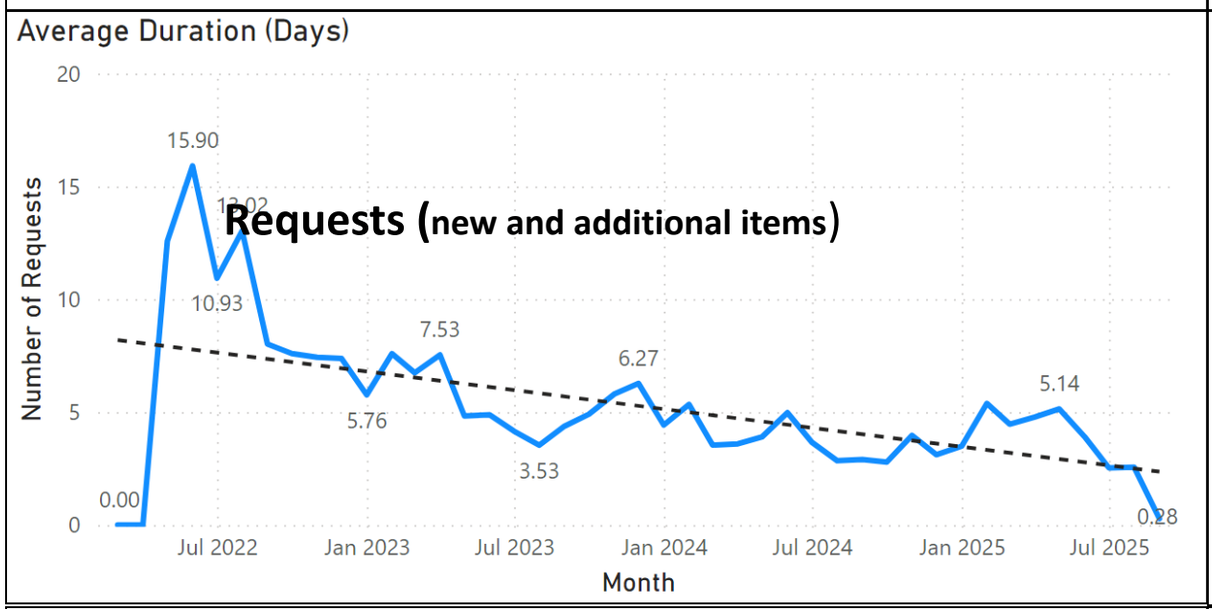
Service Desk Scorecard

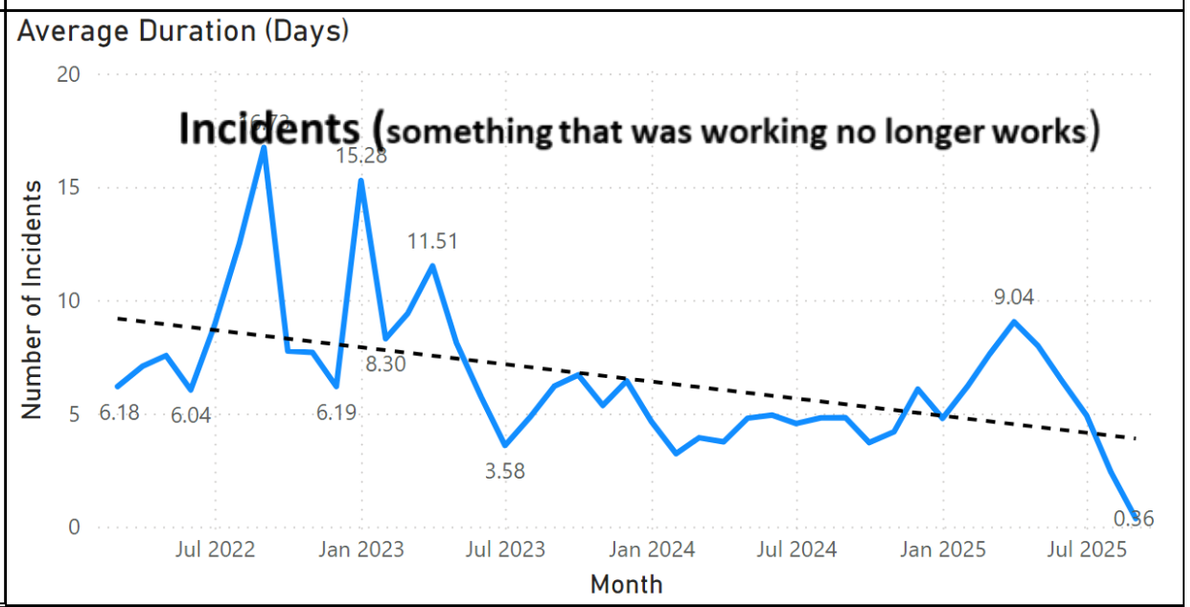
Shaping Our Future
Digital Services

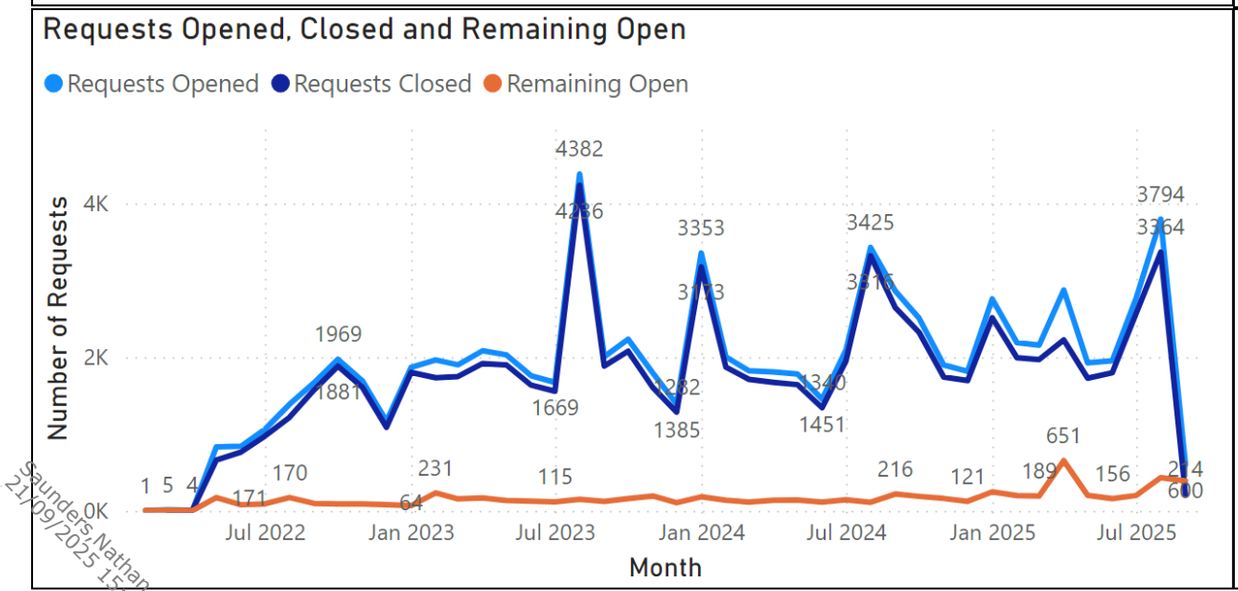
Year 2024		Current Year		Current Month	
Incidents	**Requests**	**Incidents**	**Requests**	**Incidents**	**Requests**
18247	26795	10886	21002	299	600
Incidents Opened	Requests Opened	Incidents Opened	Requests Opened	Incidents Opened	Requests Opened
18240	25053	10559	18354	182	214
Incidents Closed	Closed Requests	Incidents Closed	Closed Requests	Incidents Closed	Closed Requests
7	1742	327	2648	117	386
Remaining Open	Remaining Open	Remaining Open	Remaining Open	Remaining Open	Remaining Open
4.40	3.68	6.19	3.81	0.36	0.28
Avg Duration (Days)	Avg Duration (Days)	Avg Duration (Days)	Avg Duration (Days)	Avg Duration (Days)	Avg Duration (Days)

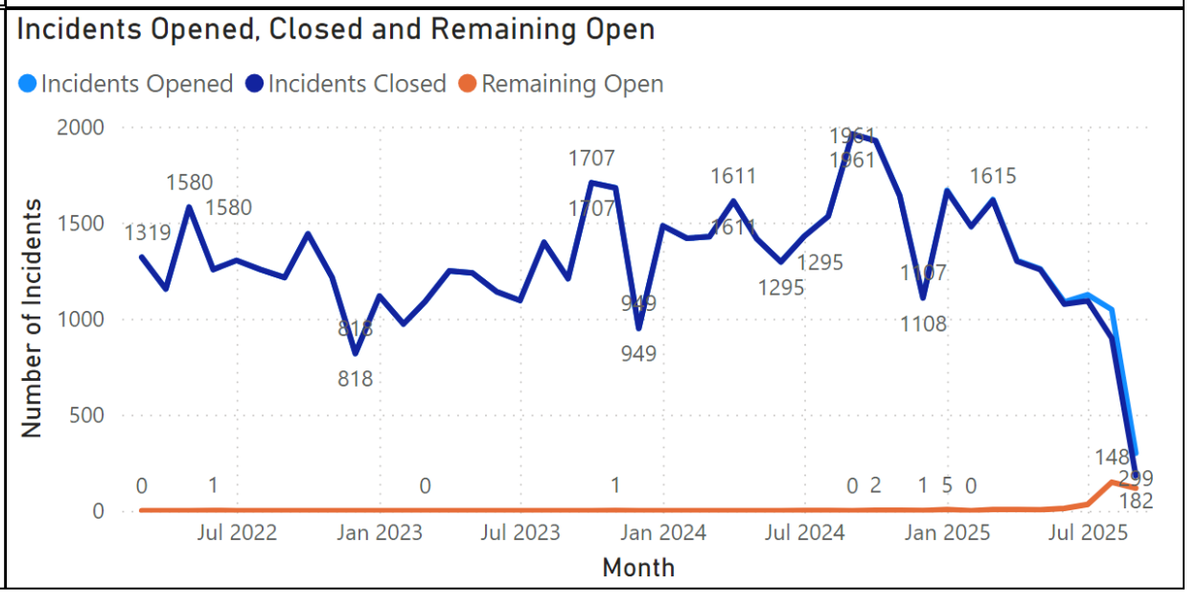
Shaping Our Future
Digital Services

Service Desk Trending



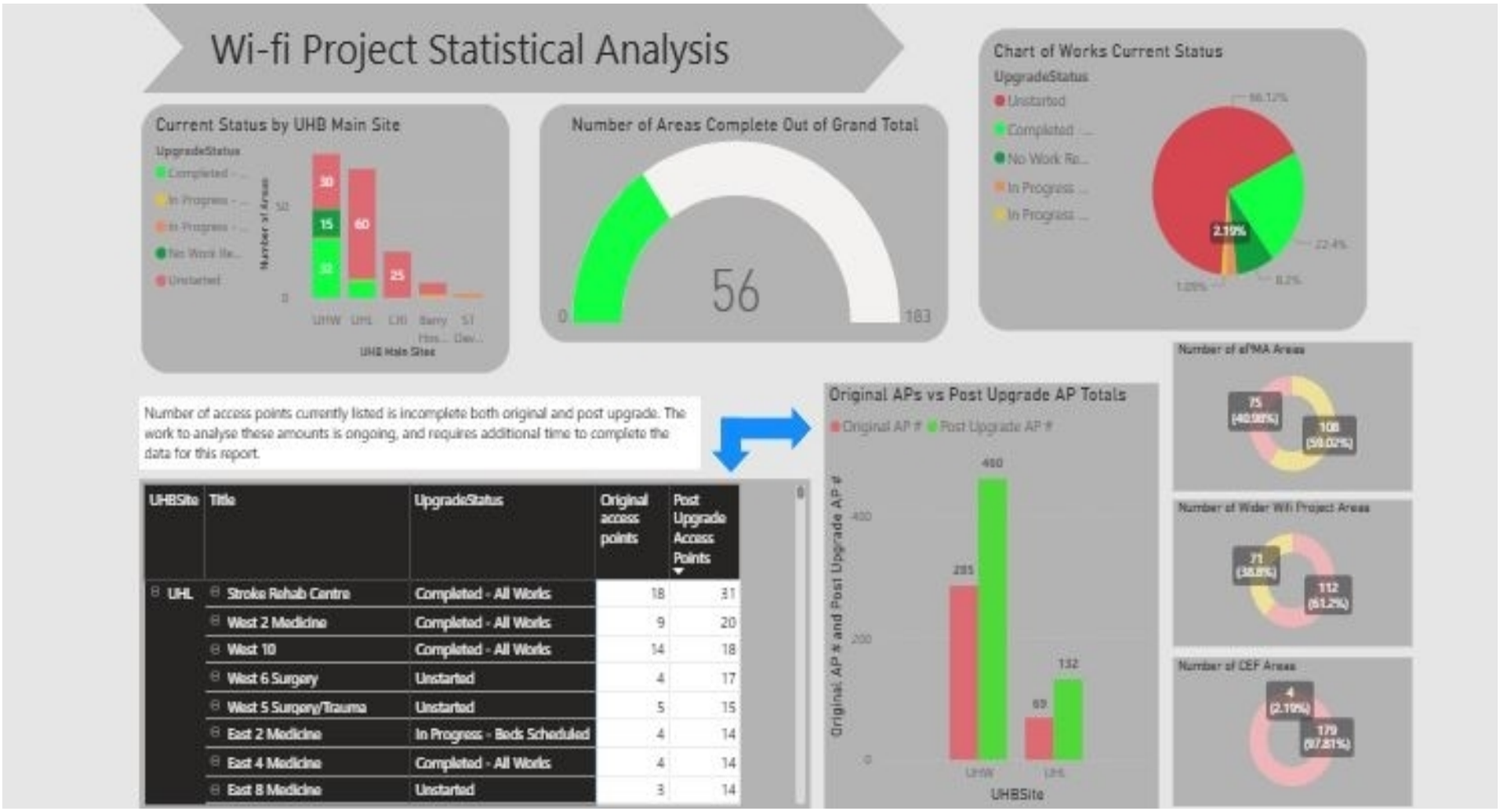






Shaping Our Future
Digital Services

WiFi Project



UHBSite	Title	UpgradeStatus	Original access points	Post Upgrade Access Points
UHL	Stroke Rehab Centre	Completed - All Works	18	31
	West 2 Medicine	Completed - All Works	9	20
	West 10	Completed - All Works	14	18
	West 6 Surgery	Unstarted	4	17
	West 5 Surgery/Trauma	Unstarted	5	15
	East 2 Medicine	In Progress - Beds Scheduled	4	14
	East 4 Medicine	Completed - All Works	4	14
	East 8 Medicine	Unstarted	3	14

Total Areas:	Total areas complete	% total of areas complete
183	62	34%

Total ePMA Areas **	Total areas complete	% total of areas complete
108	56	52%

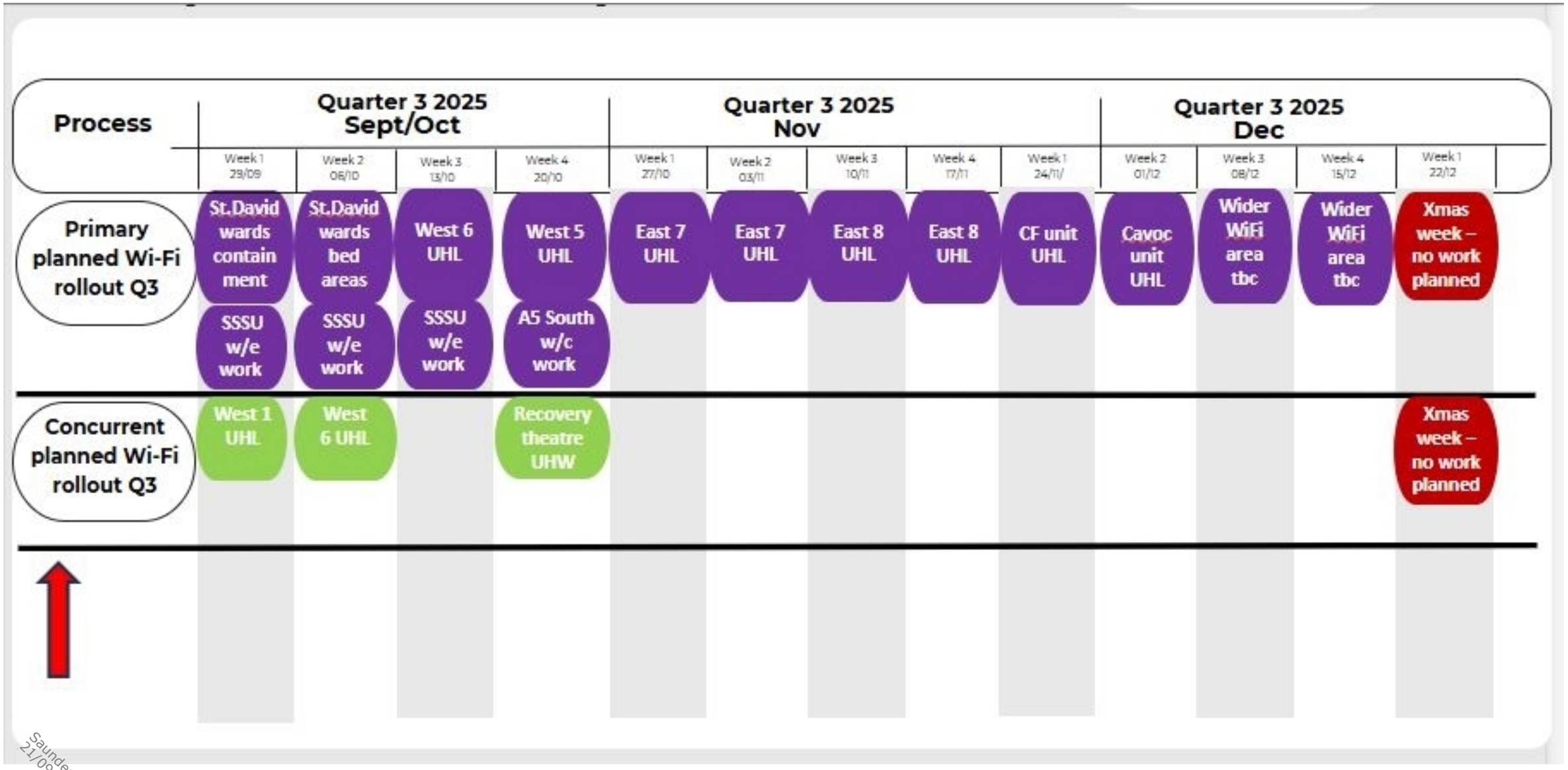
Total wider Wi-Fi/CEF areas	Total areas complete	% total of areas complete
75*	6	8%

The above shows all identified areas across the uHB assigned to the Wi-Fi project and can be filtered to show each specific site locations e.g ward A6 UHW and by overall site e.g. UHW, UHL, St, Davids etc. It also shows:

- The current 'status' of each area as follows: Un-started, In progress - containment only scheduled, In progress – bed areas scheduled and Completed – all works.
- The total number of areas completed across all areas (Wider Wi-Fi, ePMA and CEF), just ePMA areas completed and just wider Wi-Fi and CEF areas completed.
- The number of original AP's situated and how many additional ones will be required to get the Wi-Fi up to standard. Please note this still needs to be filled in for some areas and is currently WIP.

Shaping Our Future
Digital Services

Phase 5 Wi-Fi work schedule



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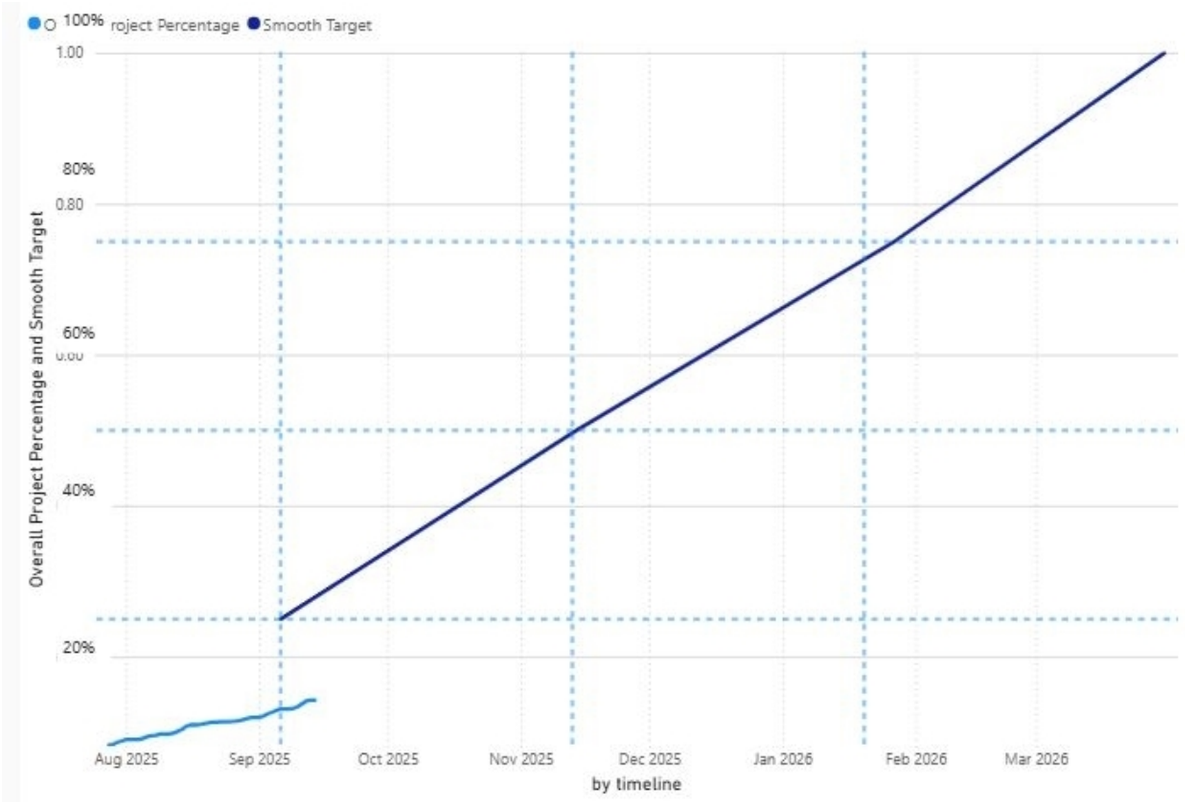
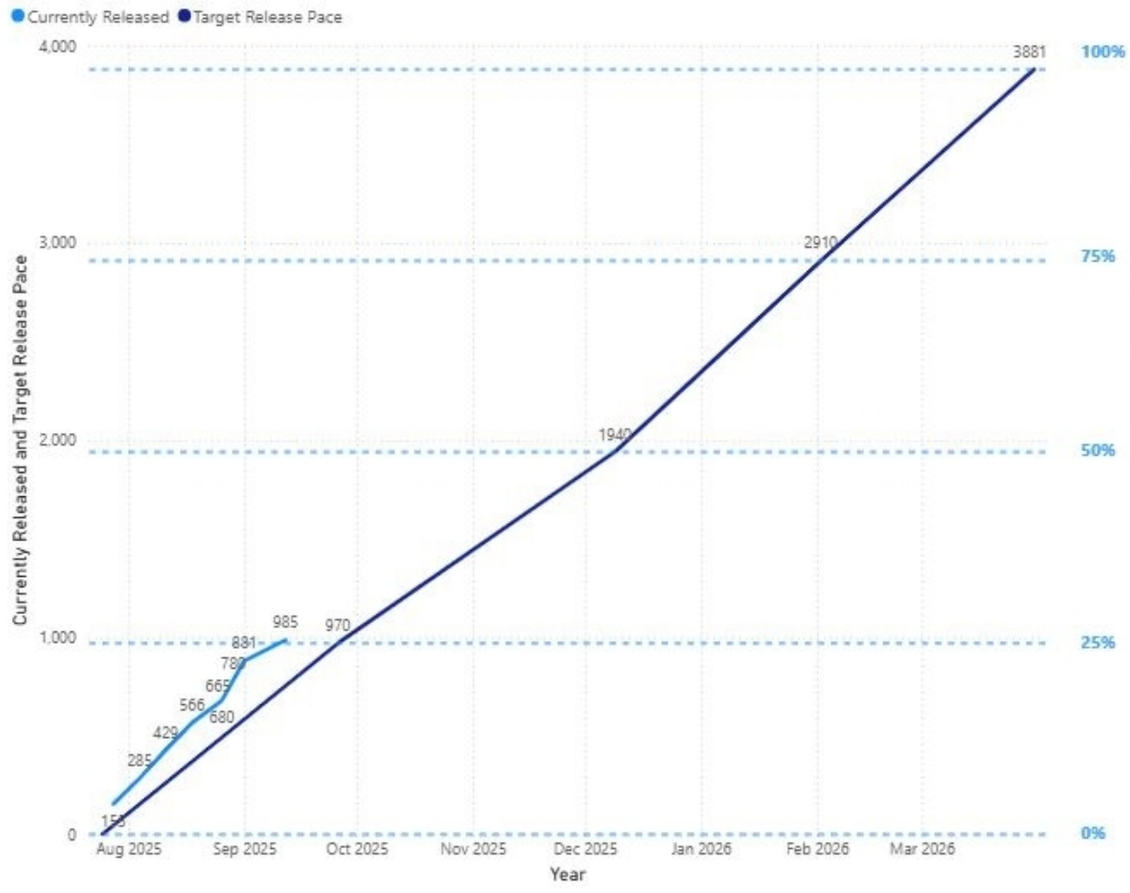
Shaping Our Future
Digital Services

Windows 11 Project





- Graph 1 displays the overall progress of the replacements against the project timeline, with markers at 25% of time passed (vertical) and 25% of project complete (horizontal).
- Graph 2 displays the release of stock from storage to preparation, in readiness for deployment to locations around the hospital.

Strategic Portfolio Executive Steering Group Report to Board

September 2025

Introduction

Twice yearly, the Executive Steering Group provides an opportunity for the executive team to collectively review progress, delivery and emerging priorities across all strategic portfolios, ensuring assurance to both the CEO and collectively as an Executive team. The recent meeting took place as part of a strategy away day on 12th September, which featured presentations from each of the portfolio SRO's and Executive chairs, fostering robust discussion and debate on scope, dependencies, risks, and impact as well as emerging priorities for the coming year.

The current context and some key questions were set at the beginning of the day for attendees to revisit during discussions.

1. Our strategic objectives – are they still valid? Does our ambition match our ability to deliver?
2. Our strategic shifts – Have we focussed on the right things to make the strategic shifts?
3. Have we done enough strategic work versus tactical?
4. What will be minimum our collective effort next year?

A follow up session will be booked in the next month with the Executive team to reflect on the Board discussion and focus on areas of synchronisation identified through group discussion.

Key Takeaways

1. **Partnerships**:
   There is a critical need to strengthen partnerships to deliver transformation plans. We must collectively face into these and be clear about how we do this constructively to ensure best outcomes.
2. **Clinical Services Plan & plans for an Integrated Community Care System (ICCS)**:
   All portfolios are dependent on the development of the Clinical Services Plan (CSP)

and its alignment with the Integrated Community Care System (ICCS), which will define the future system and model of care.

3. **Organisational Redesign**:
   Redesigning the organisation is essential to create the right conditions for delivering the desired future model of care described in our plans.
4. **Quality Management System (QMS)**:
   The QMS should inform the future governance model, ensuring robust quality assurance and improvement.
5. **Key Enablers and Cross-Cutting Themes**:
   Enablers:
   a. Workforce planning (see below for further detail)
   b. Digital transformation, specifically data and business intelligence
   c. Estates and infrastructure modernisation
   d. Financial sustainability
   e. Cultural transformation and leadership

   Cross Cutting themes:
   a. Quality
   b. Value
   c. Sustainability
   d. Research

Shaping Our Future Portfolio Summaries

1. Population Health & Places

- **Overview**:
  Focuses on embedding population health and place-based planning, supporting the ambition to become an ICCS with integrated models of care and proactive, coordinated delivery.

- **Achievements**:
  - Progress in diabetes prevention, vaccination, healthy weight, tobacco control, and ICCS establishment.
  - RAG status shows improvement, but red risks remain around planning groups and children's respite care.
- **Emerging Priorities**:
  - Continue ICCS Phase 1 delivery, roll out Cluster MDTs, Urgent Care Centre delivery, and digital hub development, further engagement with clusters.

  - Maintain focus on reducing health inequalities (vaccination, smoking, obesity, diabetes). Connecting the whole pathway of care building on the work on diabetes and ambition to map existing and future pathways and broadening this across portfolios. Exemplar pathway opportunities for planning (metabolic health emerging discussion)
- **Dependencies**:
  - Strong partnership working and being clear on what the Health Board role is and ensure that we are organised to deliver
  - Digital and estates plans, workforce capability, and organisational restructure. UHB leadership for Places programme will be key to ensuring successful ICCS
- **Risks**:
  - Whole-system change required, financial and digital infrastructure constraints, stakeholder engagement, and estate suitability. Requires a shift in discussion from funding to resources.

2. Clinical Services

- **Overview**:
  The Clinical Services Plan (CSP) is the blueprint for CAVUHBs future models of care, this is the focus for development in 25/26. Programmes focus on partnerships as critical enablers for service transformation and span; SEW regional partnerships, Velindre partnership, and specialised services partnership.
- **Achievements**:
  - Significant reduction in long-waiting patients, best cancer outcomes in Wales, and progress in orthopaedic planning and cataract pathways with reduction in waiting times and greater equity across the SEW region.
- **Emerging Priorities**:
  - Ministerial asks on waiting times, emergency care targets will remain but are tactical in approach.
  - Service planning aligned to the CSP
  - Tertiary services strategy in partnerships and regional service plans

- **Dependencies**:
  - ICCS, OD & People & Culture plans, infrastructure, digital/data, and partnerships.
- **Risks**:
  - Partnership dependencies, provider/commissioning risks, data quality, and cultural mindset shifts.

3. Future Generations

- **Overview**:
  Commitment to sustainability, innovation, and protecting future generations through research, climate response, and foundational economy initiatives.
- **Achievements**:
  - Cardiff Health Partners and Cancer Research Hub launched, multiple innovation projects, sustainability projects (decarbonisation, EV fleet, recycling).
- **Emerging Priorities**:
  - Develop baseline portfolio position, embed robust KPIs, establish engagement approaches, and deliver the Climate Response Strategy.
- **Dependencies**:
  - CSP, Population Health Plan, Cardiff Health Partners, local authorities, universities, industry, and research networks.
- **Risks**:
  - Climate risks, workforce retention, financial constraints, infrastructure, data/digital, and embedding RD&I.

4. Quality & Value

- **Overview**:
  Two programmes included within the scope, the SOF Quality Excellence programme and Value aiming to ensure CAVUHB collectively eradicates avoidable harm and embeds value-based healthcare approach.
- **Achievements**:
  - Five prioritised quality projects established, robust reporting and measurement, and progress in value-based pathways as the programme continues to roll out across the organisation.
- **Emerging Priorities**:
  - QMS-informed approach, robust change control, scaling of projects, and embedding PROMs and value impact tracking.
- **Dependencies**:
  - Data availability, governance, cross-board partnerships, and leadership.
- **Risks**:
  - Resource constraints, digital/data limitations, and funding for programme expansion.

5. People & Culture

- **Overview**:
  Focus on staff wellbeing, workforce capability, inclusivity, sustainability, and a values-driven culture.
- **Achievements**:
  - Attendance management improvements, reduction in long-term sickness, e-rostering, leadership development, and workforce planning expertise.
- **Emerging Priorities**:
  - Refresh People & Culture Plan ensuring articulation of strategy delivery to 2035 in addition to the national workforce plan alignment`, reduce objectives to four core 'promises'and consider coproduction of mutual expectation between employees and employer , embed workforce intelligence, further develop interprofessional and cross organisational workforce planning, and strengthen EDI and Welsh language.
- **Dependencies**:
  - Clinical Services, Infrastructure, Population Health, Digital Strategy.
- **Risks**:
  - Financial sustainability, workforce fatigue, recruitment gaps, operational pressures, digital and environmental infrastructure, and leadership capacity.

6. Infrastructure

- **Overview**:
  Alignment of digital and estates strategies, with programmes in digital foundations, estates strategy, and hospital masterplanning.
- **Achievements**:
  - Digital rollouts (365 Copilot, WiFi, ePMA), estates surveys, decongestion plans, and newborn screening enablement.
- **Emerging Priorities**:
  - Digital strategy refresh, national digital programmes, secure infrastructure, and estates strategy informed by CSP & ICCS.
- **Dependencies**:
  - Clinical Services, Population Health, People & Culture, Future Generations, external partners.
- **Risks**:

- Capital availability, data quality, national programmes, lack of long-term CSP, ICCS clarity to inform plans, lack of Business Intelligence capability and capacity increased risk due to transition away from LightFoot will impact available information and decision making.

Cross-Cutting Themes & Enablers

- **Quality, Research and Sustainability**
  Were all identified as cross cutting areas that require greater interface with all portfolios
- **Workforce Planning**:
  Central to all portfolios, requiring robust planning, upskilling, and retention strategies.
- **Digital Transformation and Analytics**:
  Investment in digital infrastructure and data analytics is essential for service redesign and workforce productivity.
- **Financial Sustainability**:
  Tight cost control and efficiency are required to support transformation.
- **Cultural Transformation**:
  Compassionate leadership, inclusivity, and continuous improvement underpin all strategic objectives.

Risks and Dependencies

- **Critical dependencies** exist between portfolios, especially regarding the CSP, ICCS, digital, estates, and workforce plans.
- **Risks** include financial constraints, workforce shortages, digital/data limitations, and the need for cultural and organisational change.

Conclusion & Next Steps

The Group reaffirmed the importance of integrated planning, partnership working, and a relentless focus on quality, value, and sustainability across portfolios to ensure success. The Board is asked to note the progress, endorse the emerging priorities, and support the continued alignment of portfolios to deliver the organisation's strategic objectives for 2026/27 and beyond.

Report Title:	Outline Business Case for Llantrisant Health Park (LHP) Community Diagnostic Hub (CDH)			Agenda Item no.	7.1.1
Meeting:	CAVUHB Board	Public	x	Meeting Date:	25.09.2025
		Private			
Status *(please tick one only):*	Assurance		Approval		Information x
Lead Executive:	Catherine Phillips, Executive Director of Finance and Interim Director of Planning				
Report Author (Title):	Victoria Le Grys, Shaping Our Future Clinical Services Programme Director Robert Mahoney, Deputy Director of Finance				

Main Report

Background and current situation:

1.1 In December 2022, CTMUHB submitted a successful business case to the Welsh Government (WG) to purchase the former British Airways Avionics Engineering site at Llantrisant, with the purchase of the site completing in February 2023.

1.2 The vision for the LHP site is to establish a standalone site for high-volume, low-complexity surgical and diagnostic procedures to address capacity shortfalls, meet future demand challenges and support consolidation of services where this will add value to health boards in South East Wales.

LHP will also act an enabler for further regional service reconfiguration. The development of a dedicated facility for planned care, separated from emergency care, was a key commitment in the Welsh Government's recovery document, "Our Programme for transforming and modernising Planned Care and reducing waiting lists in Wales" (April 2022).

1.3 The project is being led by the LHP Project Team at CTM in partnership with ABUHB and CAVUHB. Health Boards in South East Wales have committed to active collaboration where this delivers added value to clinical service delivery, access, and sustainability.

1.4 The development of LHP will be undertaken via a phased approach which has been supported by WG. Phase 1 is the development of a DH. Phase 2a will include a high volume, low complexity orthopaedic inpatient unit. The final Phase 2b, will include a multi-modality day surgery unit. This OBC specifically refers to Phase 1.

2. Specific Matters for Consideration

2.1 The purpose of the Phase 1 LHP OBC is to outline key objectives, current plans for investment and to seek approval for funding from Welsh Government to proceed to Full Business Case (FBC) for the CDH element of the LHP. This OBC supports the improvement of regional access to regional Community Diagnostic services including Radiology (CTMUHB only) and Endoscopy (regional).

2.2 The regional Endoscopy case was submitted and approved by CAVUHB Board in March 2025 alongside the Strategic Case for the LHP.

2.3 The attached OBC sets out the strategic, economic, commercial and financial case for the development. This document is still in draft form on submission to VBRG as work continues at pace to complete it prior to submission to WG.

2.4 The CDH proposal incorporates:

- Imaging capacity – incorporating MRI, CT and NOUS
- Endoscopy capacity – elective and screening services to increase capacity across the region
- Training capacity - working with HEIW, the scheme offers a diagnostic training academy space which links into existing endoscopy suites and provides a base for the endoscopy training academy as well as resources and facilities to support the wider diagnostic training facilities.

2.5 The Phase 1 LHP OBC also includes the development of the wider site infrastructure requirements. This will mitigate the impact on the CDH once operational in regards to later phases of construction (Phases 2a and 2b).

2.6 WG agreed for early submission of the Phase 1 LHP OBC prior to Board approval to enable scrutiny of the OBC to commence without a delay to overall programme timelines. This is critical in ensuring the FBC submission to Welsh Government in December 2025 (following November Board approval).

2.7 The Phase 1 LHP OBC is being presented to CTMUHB Board for approval and to ABUHB and CAVUHB boards for information and not approval. This is because the CDH contract will be held by CTMUHB, CAVUHB and ABUHB will commission activity from this contract and will not be contract holders, but it is critical that both Health Boards support the development.

3. Key Risks / Matters for Escalation

3.1 The key risks are set out in section 4.3 in the attached OBC.

3.2 The key risk currently is the non-approval of the OBC by WG. To mitigate this risk, a thorough approach is being taken to the development of the OBC, supported by robust governance arrangements.

3.3 Final confirmation and support will be subject to the availability of appropriate revenue funding when LHP becomes operational. The level of required revenue funding will be determined by the required demand at that point and the independent provider market costs arising from the tender process which is currently underway.

4. Next Steps

4.1 Subject to Board approval from CTMUHB, the Phase 1 LHP OBC will be submitted to Welsh Government.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

CAVUHB specific assessment of the documents

- **Strategic Alignment:** The LHP aligns to CAVUHB's strategic objectives and regional planning principles.

- **Commissioning Intentions:** CAVUHB Board's endorsed (March 2025) commitment to commission endoscopy capacity from LHP from 2027/28, with a focus on maximising internal efficiencies and workforce planning.
- **Revenue Funding:** Support is contingent on securing additional revenue; this remains a key risk.
- **Workforce Planning:** CAVUHB is committed to maximising internal efficiencies and detailed workforce planning as regional plans develop.
- **Operational Impact:** The CDH will support reduced waiting times and improved patient outcomes for CAVUHB residents.

CAVUHB specific risks and issues

- **Revenue funding risk** (external support required). Therefore, the proposal should be supported in principle whilst a clearer picture of requirements emerge through the tender process.
- **Workforce** transition and sustainability.
- **Ongoing engagement** is required with regional partners and stakeholders including the public on the service redesign.

The Outline Business Case for Llantrisant Health Park Community Diagnostic Hub can be found in the supporting documents folder.

Recommendation:

The Committee are requested to:

- **Note** the regional planning direction and the OBC for LHP CDH.
- **Note** the CAVUHB's assessment above of the documents and the risks and issues set out above.
- **Support** the submission of the case to Welsh Government following CTMUHB Board approval
- **F&P support** the recommendation to Board on the basis there is sufficient revenue made available

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

Putting People First	X	Providing Outstanding Quality	X
Delivering in the Right Places	X	Acting for the Future	X

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term	x	Integration		Collaboration	x	Involvement	x

Quality Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes
The LHP programme and wider regional portfolio regularly monitor and manage a full risk and issues registers for all programmes and constituent projects
Safety: No
Financial: Yes
Contained within the papers
Workforce: Yes
Contained within the papers
Legal: Yes
To be considered through the regional programme
Reputational: Yes
To be considered through the regional programme
Socio Economic: No
Equality and Health: Yes
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route:	
Strategic Leadership Team	11.09.25
Value Benefits Realisation Group	08.09.25
Finance and Performance Committee	17.09.25
CAV UHB Board	25.09.25

Report Title:	Regional Joint Committee			Agenda Item no.	7.2
Meeting:	Board	Public	x	Meeting Date:	25.09.25
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Deputy Director of Strategy, Planning & Partnerships - ABUHB				

Main Report
Background and current situation:

Partnership and collaborative working has been progressing across South East Wales Health Boards and Velindre NHST since September 2022 in the guise of a South East Wales regional planning portfolio. Good progress has been made during this time.

The South-East Wales Regional Joint Committee (RJC) represents an evolution of and step change in the potential for these existing arrangements and is a strategic collaboration established by direction of the Cabinet Secretary for Health and Social Care. It more formally brings together Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Health Board to oversee regional planning and service delivery for a catchment population exceeding 1.5 million, noting the service provision of these organisations reaches beyond this.

The RJC aims to enhance collaboration, reduce inequalities, and promote sustainable healthcare services across the regional footprint and represents a significant step toward integrated regional health governance through collaborative leadership and shared accountability among the constituent health boards and associate members.

The attached Terms of Reference provides a comprehensive framework for its operation and governance, ensuring that regional health needs are met effectively and efficiently.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Status and Authority

The RJC is formed under the powers of the Welsh Ministers pursuant to the National Health Service (Wales) Act 2006. It is not a separate legal entity but a joint committee accountable to the Boards of the three constituent health boards. Each board delegates certain functions to the RJC, which is bound by these decisions under the schedule of delegated powers. The health boards retain ultimate responsibility for the planning and delivery of health services to their populations but may choose to be bound by a majority view at the joint committee.

The RJC's Terms of Reference includes a schedule of reserved and delegated powers which clarifies the division of responsibilities between the health boards and the RJC, ensuring clear governance and accountability.

Chief Executives of the health boards serve as Accountable Officers with personal responsibilities for financial propriety, sustainability, value for money, risk management, and accurate accounting. Their membership in the RJC ensures decisions respect these duties, avoiding conflicts between personal responsibilities and board roles.

Purpose and Objectives

The RJC seeks to transform regional collaboration by providing collective leadership for planning, commissioning, and delivering health services. It focuses on aligning clinical service development with population health needs, addressing service and financial challenges, and reducing unwarranted variation in outcomes and access. Specific objectives include developing a regional work programme, reviewing baseline activities for efficiency and quality, prioritizing capital projects, approving business cases, and ensuring integrated impact assessments for service change.

Chairing and Membership

Upon establishment, the RJC will appoint a Chair from the Health Board Chair represenatives and rotate annually thereafter between the three health board Chairs. Membership of the RJC includes representatives from each health board, including Chairs, Vice Chairs, Chief Executives, and nominated Executive Directors. Associate membership is extended to representatives from Powys Teaching Health Board and Velindre University NHS Trust, who attend meetings without voting rights. The committee may invite additional attendees to assist its work, including representatives from the wider health and care system and community sectors.

Values, Behaviours and Principles

The RJC will operate under four core partnership principles:

- A system-focused partnership aiming for agreed population outcomes.
- A system enabler fostering collaboration.
- A low-bureaucracy, high-trust environment.
- A culture of constructive behaviours.

RJC members will be expected to adhere to their respective health board policies, NHS Wales values, Nolan Principles, and agreed partnership principles. They must consider equality, diversity, and inclusion in decision-making and prioritize regional population interests over individual health board interests.

The RJC will promote openness and transparency by holding public meetings where possible, while safeguarding confidential information as necessary. Conflicts of interest will be managed per health board policies, with declarations required at meetings and appropriate actions determined by the RJC Chair or Vice-Chair.

Disputes between health boards related to RJC operations will follow a structured resolution process beginning with discussions among involved parties, escalating to chief executives, then chairs, and ultimately to the Welsh Government Director General and Cabinet Secretary if unresolved. This process emphasizes cooperative resolution in line with the agreed partnership principles.

Meetings and Decision-Making

The RJC will typically meet quarterly, with a minimum of three meetings per year. A quorum requires at least six members, including an Independent Member and an Executive member from each health board.

Decisions will be reached by consensus or, in exceptional circumstances, by vote among RJC members or referral to respective health boards. Meeting notices and papers are distributed in advance, and meetings are conducted with transparency, including public sessions when appropriate.

Governance support to the RJC will rotate annually among the health boards based on the chairing arrangement in place.

Review and Reporting

The effectiveness of the RJC will be reviewed annually, with reports submitted to the health boards. The Terms of Reference will also be reviewed regularly to ensure they remain relevant and effective with an initial review planned to take place six months after establishment.

RJC meeting minutes and summary reports will be shared with the health boards for assurance and transparency.

Creating the wider conditions for success

There is an abundance of evidence however which suggests structural change by itself is not a likely route to successful or sustainable regional service delivery / improvement.

Establishing successful partnerships between organisations requires shared objectives and demands the engagement of 'hearts and minds' across all levels of the system.

Emotional and cultural alignment will be essential to build trust, foster collaboration, and ensure that joint working is sustained through periods of change and challenge. Trust and psychological safety will also be foundational to an effective partnership. When individuals and teams believe in each other's intentions and feel safe to express concerns or ideas, they are more likely to engage openly and constructively. This environment will also support shared problem-solving and reduce the risk of siloed thinking or defensive behaviors.

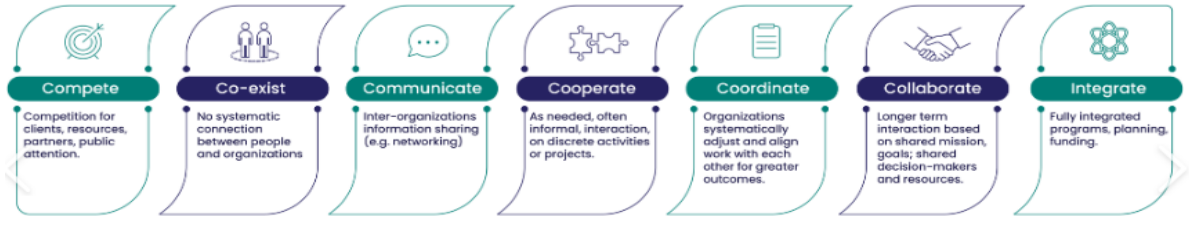
Creating these wider conditions will require a number of actions / considerations to be progressed in the early phase of the RJC -

a) Development of a value proposition and shared sense of purpose that goes beyond that laid out by the Minister.

Aligning purpose alongside further developing and embedding values (described above) across the RJC and constituent partners will help to create a unified direction. While partners will have different operational pressures ensuring that all partners are committed to a common vision for patient care and system improvement will translate into stronger ownership of shared goals and greater resilience in the face of operational or financial pressures.

b) Assessment of the spectrum of collaboration.

The extent to which any partnership collaborates can vary considerably (as shown in the spectrum of collaboration below). Ensuring a collective acknowledgement on both where the current partnership is and where the RJC does, and does not, strive to get to will be vital in building trust and transparency. It will guard against any particular partner being unfairly labelled 'difficult' merely because their expectations of the partnership differs from others but has not been fully understood from the outset.



The Tamarack Institute. (June, 2017). *The collaboration spectrum - tool* [Illustration]. The Tamarack Institute. https://www.tamarackcommunity.ca/library/collaboration-spectrum-tool

The Center for Implementation

Figure adapted by The Center for Implementation

c) Exploration and agreement of the partnerships 'sweet spot' in terms of responsibility at scale v's at-site.

The more ‘at scale’ the partnership operates the more diluted the benefits of strong local/organisational leadership. The stronger the local/organisational leadership the less likely the partnership will achieve benefits at scale.

The choice of ‘at scale’ or ‘at site’ need not be a binary one but a transparent conversation between partners as to where the collective ‘sweet spot’ is for the RJC will enable progress at a pace that all partners are comfortable with.

Trust and a willingness to work in collaboration can often be eroded through frustration at the perceived pace of progress, or lack of. Learning and reflections on regional working over the past three years has shown that too often partners have focused, too heavily, on specific regional models of care that need deploying compared to other foundational elements that also need time and attention. These would ultimately support delivering those service models at greater pace. Further consideration thus needs to be given to;

d) Wider enablers of effective collaboration.

A focus on achieving collective consensus at an RJC level on the approach towards a number of key enablers will provide the foundations for collective service delivery at scale.

These enablers will include how clinical leadership is embraced, how digital (including data sharing) solutions are best exploited across organisational boundaries and also how regional approaches to workforce are best developed.

e) ‘Alignment versus assimilation’

An equal focus on building trust through considering an early emphasis on aligning and stream-lining pathways, standardising clinical policies, joint management / clinical leadership models as opposed to moving directly to regional delivery of service (assimilation of services) will also help build confidence within the RJC.

In creating the wider conditions for success and to ensure the RJC meets from a position of strength points a – e above should be considered through the development of a regional Organisational Development (OD) programme that is wrapped around the emerging RJC and its partners.

Recommendation:

Respective Boards are asked to:

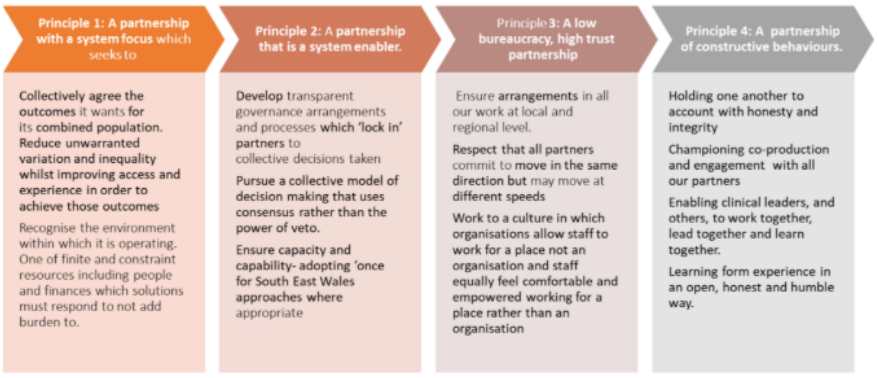
- Approve the establishment of the South-East Wales Regional Joint Committee (RJC) and its associated terms of reference and operating arrangements as attached;
- Note the RJC will appoint a Chair from its membership followed by a rotating period of appointment. Governance support will be provided by the Health Board of the Chair appointed as RJC Chair;
- Determine membership from each respective health board to join the RJC, in-line with the membership requirements;
- Note the wider determinants for the RJCs long term sustainable success and;
- Approve the development of a regional OD programme for the RJC and its partners.

SOUTH-EAST WALES REGIONAL JOINT COMMITTEE (RJC)

TERMS OF REFERENCE & OPERATING ARRANGEMENTS

Introduction	**1.** On 2 April 2025, the Cabinet Secretary for Health and Social Care directed Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Heath Board to establish a Regional Joint Committee (RJC) to exercise the facilitation and oversight of regional planning to drive effective collaboration and regional working. This direction is given pursuant to the Welsh Ministers' power in section 12(3) of the National Health Service (Wales) Act 2006. **2.** For the purpose of these terms of reference, the three organisations comprising the RJC will be referred to as the health boards. **3.** To enhance collaboration in integrated care, representatives from Powys Teaching Health Board and Velindre NHS Trust will be Associate Members of the RJC. **4.** Additionally, a Welsh Government Official is to receive a standing invitation to observe all meetings of the Committee. This will usually be a member of the Health, Social Care, and Early Years Executive Directors Team. This will provide the Cabinet Secretary with confidence that there is an appropriate level of oversight and assurance from the Welsh Government in place. **5.** The RJC is expected to bring greater focus on: • regional planning and delivery of service models. • improved outcomes and a reduction in inequalities in access. • potential for service transformation, including new workforce models. • establishing new relationships and/or resetting existing relationships. • exploring regional solutions to advance sustainable service provision • providing coordinated support to the health boards.
Status	**6.** The RJC is to be established under the powers vested in Welsh Ministers under Section 12 of the National Health (Wales) Act 2006 which allows: (1) Welsh Ministers to direct a Local Health Board to exercise in relation to its area: (a) functions which were transferred to the National Assembly of Wales (now Welsh Government following the Government of Wales Act 2006) by the Health Authorities (Transfer of Functions, Staff, Property, Rights and Liabilities and Abolition) (Wales) Order 2003 (S.I. 2003/813 (W.98)), (b) such other of their functions relating to the health service as are specified in the direction. (2) The functions which may be specified in directions under subsection (1) include functions under enactments relating to mental health and care homes. (3) The Welsh Ministers may give directions to a Local Health Board about its exercise of any functions.

Accountability, Responsibility and Authority	**7.** The RJC is established by, and ultimately accountable to, the Boards of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB. **8.** As a joint committee of the three Health Boards, the RJC is not a separate legal entity from each of the LHBs. **9.** The RJC shall report to each Board on its activities, to which it is formally accountable in respect of the exercise of the functions carried out on their behalf. **10.** Ultimately, the three Health Boards remain accountable for planning, securing and delivering health services to their respective populations. **11.** Each Health Board has delegated authority to the RJC for the exercise of certain functions, as set out within these Terms of Reference. **12.** These RJC Terms of Reference form a schedule of each Health Board's own Standing Orders and have effect as if incorporated within them. **13.** Where Health Boards have delegated functions to the RJC, each Health Board shall be bound by the decisions of the Joint Committee in accordance with the Schedule of Powers delegated to the RJC (**Appendix A**).
Purpose of the RJC	**14.** The RJC has been established to: (a) Create a step change in the effectiveness of arrangements to collaborate across the regional footprint in the interests of our shared population, marking a change in the way we work collectively as health boards. (b) Provide collective leadership for the regional planning, commissioning, and delivery of services for the population served by the three health boards, considering the service challenges, financial challenges and population health needs of all three organisations. (c) Establish a regional approach to the development of clinical services planning, aligned to regional population health needs assessments, to develop and deliver sustainable services in terms of achieving quality and outcome measures, workforce and financial sustainability. (d) Identify priorities for the three health boards, where a regional approach will deliver benefit. (e) Explore how the benefits of a regional health economy are harnessed to best serve the south-east Wales population of over 1.5million. (f) Reduce unwarranted variation and inequality in health outcomes, access to services and experience at a regional population level. (g) Be cognisant of the wider environment of health services in Wales, including the needs of those who use health services in the south-east Wales region but are from populations which are outside of the responsibility of the three health boards.

Objectives of the RJC	**15.** In-line with delegated levels of authority and accountability (**Appendix A**), the RJC will specifically: a) Develop a regional programme of work, aligned to individual Health Board plans, to ensure the benefits of a regional health economy for a population of over 1.5million are realised. b) Review baseline activity, based on individual Health Board clinical services plans, focusing on cost efficiencies, quality, and service fragility. c) Develop and oversee an approach to prioritisation of capital programmes which underpin the regional health economy approach. d) Consider and prioritise the regional projects included within the regional programme of work, approving Business Cases and identifying and agreeing to any further projects to be included in the regional programme. e) Seek assurance that projects deliver against their outcomes and timescales, and deliver against the quality measures and programme benefits, as identified in their PIDs and or Business Cases. f) Provide a vehicle to progress work programmes within the remit of the RJC without unnecessary recourse elsewhere to ensure pace. g) Seek assurance that integrated impact assessments are undertaken of all planned service change programmes and embedded in the ways of working of the RJC. h) Develop, implement and evaluate the required governance framework to deliver the regional programme of work, underpinning the RJC. i) Consider any audit and review related activity relevant to the work of the RJC to inform learning and improvement.
Partnership Principles	**16.** As a strategic partnership of the three Health Boards in the region, the RJC will adopt and embed the following four partnership principles into its business and operating arrangements. The RJC will be: a) A partnership with a system focus which seeks to collectively agree the outcomes it wants for its combined population. b) A partnership that is a system enabler. c) A low bureaucracy, high trust partnership. d) A partnership of constructive behaviors. 

Chairing Arrangements	**17.** The Chair of the RJC will be drawn from one of the Chairs of the three health boards and this position will rotate amongst the three chairs on an annual basis at the meeting of the RJC in April of each year. The RJC will be established in October 2025 and the first appointed Chair will serve until March 2027. **18.** The other two health board Chairs will jointly become vice chairs of the RJC and will agree who deputises and presides at a meeting in the absence of the Chair.
Membership	**19.** The RJC shall have the following members drawn from the three health boards, as follows: • Chairs of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB (3) • Vice Chairs, or 1 nominated Independent Member, of each of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB (3) • Chief Executives of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB (3) • 1 nominated Executive Director from each of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB (3) **20.** With the permission of the Chair of the RJC, the members of the RJC set out above may nominate a substitute, equivalent Board Member (as defined above) to attend a meeting that they are unable to attend. The substitute may speak and vote on their behalf. The decision of the Chair regarding the authorisation of nominated substitutes is final.
Associate Membership	**21.** The RJC shall have the following associate members, attending meetings on an ex-officio basis, without voting rights: a) A nominated Board Member of Powys Teaching Health Board (1) b) A nominated Board Member of Velindre NHS Trust (1) **22.** With the permission of the Chair of the RJC, the associate members of the RJC set out above may nominate a substitute to attend a meeting that they are unable to attend. The substitute may speak on their behalf. The decision of the Chair regarding the authorisation of nominated substitutes is final.

In Attendance	**23.** At the discretion of the Chair of the RJC, the RJC may invite others to attend meetings, where this would assist it in its role and in the discharge of its duties. This may include, but is not limited to: a) Employees of the three Health Boards as appropriate. b) The Senior Responsible Officers of RJC programmes. c) Representatives from the Health and Care system, including NHS Bodies and Local Authorities. d) Representatives from the Voluntary, Community and Social Enterprise sector. e) Representatives of Llais. **24.** The RJC will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the RJC (whether directly or through the activities of bodies such as Llais) and to demonstrate openness and transparency in the conduct of business. **25.** A Welsh Government Official will receive a standing invitation to observe all meetings of the RJC.
Accountable Officers	**26.** Chief Executives of Health Boards are designated Accountable Officers, in-line with *Managing Welsh Public Money*, and hold several personal responsibilities. Accountable Officers have a personal responsibility for: propriety and regularity of the public finances delegated to them; affordability and sustainability; value for money; management of opportunity and risk; learning from feedback; and accounting accurately. **27.** The Chief Executive, as the Accountable Officer (Accounting Officer), of each respective Health Board is included within the membership of the RJC to ensure any decisions delegated from Boards to the RJC do not undermine the personal responsibilities Accountable Officers hold. **28.** Accountable Officers will need to be cognisant of their responsibilities, as set out within *Managing Welsh Public Money (MWPM)* and their respective Accountable Officer Memorandums, ensuring principles are applied to decision making, including: a) MWPM 3.8.5 – "There are sensitivities about the role of the Accounting Officer in a public body which is governed by an independent board, e.g. a charity or a company. The Accounting Officer, who will normally be a member of the board, must take care that his or her personal responsibilities do not conflict with his or her duties as a board member. In particular, the Accounting Officer should vote against any proposal which appears to cause such a conflict; it is not sufficient to abstain." b) MWPM 3.8.6 – "Moreover, if the chair or board of such a public body is minded to instruct its Accounting Officer to carry out a course inconsistent with the standards in box 3.1, then the Accounting Officer should make his or her reservations clear, preferably in writing…."

Working with Llais (Citizen Body for Health and Social Care)	**29.** In exercising its responsibilities, the RJC shall ensure arrangements are in place to engage and co-operate with representatives of Llais as appropriate. **30.** Part 4 of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (the 2020 Act) places a range of duties on Local Health Boards and Trusts in relation to the engagement and involvement of Llais in their operations, which are extended to the activities of the RJC. **31.** The RJC will ensure it is clear who will assume responsibility for engaging and co-operating with Llais when planning, developing, considering proposals for service change, in-line with delegated levels of authority.
Delegated Functions and Powers	**32.** When exercising any Delegated Functions, the RJC will ensure that it acts in accordance with, and that its decisions are informed by, the relevant policies and procedures which have been developed by the three health boards to support those functions and to inform the commissioning, provision and delivery of any relevant services. **33.** Within the framework approved by each Health Board and set out within these RJC Terms of Reference, and subject to any directions that may be given by the Welsh Ministers; the RJC may make arrangements for certain functions to be carried out on its behalf, so that regional planning and delivery may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the RJC must set out clearly the terms and conditions upon which any delegation is made. **34.** The RJC's determination of those matters that it will retain, and those that will be delegated to others shall be set out in **Appendix A**: a) Schedule of matters reserved for the RJC; and a b) Scheme of delegation to joint sub-Committees and others; all of which must be formally adopted by the RJC and approved by Health Boards as a schedule to their own Standing Orders.
Sub-Committees, Groups and Panels	**35.** The RJC may and, where approved by the LHB Boards jointly, or directed by Welsh Ministers, must appoint joint sub-Committees of the RJC either to undertake specific functions on the RJC's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees). **36.** This may also extend to: a) Programme and Project Governance – Established to provide a framework for managing and controlling programmes and projects. b) Expert Panels – Established to review and make technical recommendations on specific subjects which generally consist of experts with relevant knowledge and experience within a particular field. c) Advisory Groups – Established to provide advice over an issue/range of subject matters which generally consists of an external chair and internal and/or external stakeholders to make recommendations on a specific issue.

37. The RJC shall determine a governance structure that meets its own advisory and assurance needs and in doing so the needs of the three Health Boards. These would be set out within agreed Terms of Reference and Operating Arrangements, agreed by the RJC.

Meetings

Scheduling meetings

38. The RJC will ordinarily meet quarterly, and, as a minimum, shall meet on three occasions each year. Additional meetings may be convened on an exceptional basis at the discretion of the Chair.

39. The three Health Boards may ask the RJC to convene further meetings to discuss issues on which they want RJC advice, subject to the agreement of the Chair.

Quoracy

40. In order for a meeting to be quorate there must be at least six members in attendance, which shall include:

a) An Independent Member (Chair or Vice Chair) and an Executive member (CEO or other executive) from each of the three health boards.

41. If any member of the RJC has been disqualified from participating in an item on the agenda, because of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. Nominated deputies who have been authorised by the Chair shall count towards quorum.

42. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Voting

43. The RJC will ordinarily reach conclusions by consensus. If this is not possible, the Chair may call a vote. Only members of the RJC Committee (or nominated substitute as set out in section 20) may vote; each Member is allowed one vote. The result of the vote will be recorded in minutes

44. Where there is no consensus and the likelihood of no consensus at a subsequent meeting, the Chair of the RJC will refer the decision to each Board of the three respective Health Boards for further consideration. If the same decision is not made by each of the three Health Boards, the dispute process (**Appendix B**) will be enacted.

45. Should a decision be referred to the three respective Health Boards as set out in section 44, the outcome of all three decisions will be reported to the next meeting of the RJC and recorded in minutes.

Papers and notice

46. A minimum of seven clear days' notice of all meetings is required, which

shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed. Supporting papers must be distributed at least five clear working days ahead of the meeting.

47. On occasion it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as possible to members. Urgent papers shall be permitted in exceptional circumstances at the discretion of the Chair.

Virtual attendance

48. It is for the Chair to decide whether the RJC will meet virtually. Where a meeting is not held virtually, the Chair may nevertheless agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such a meeting. How a person has attended a meeting shall be specified in the meeting minutes.

Recordings of meetings

49. Except with the permission of the Chair, no person admitted to a meeting of the RJC shall be permitted to record the proceedings in any manner whatsoever, other than in writing.

Minutes

50. The minutes of meetings will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the RJC together with the action log as soon after the meeting as practicable. The minutes shall be submitted for agreement at the next meeting.

Governance support

51. Governance Advice and Secretariat support for the RJC will be provided by the organisation from which the Chair is elected and will therefore rotate between the three Health Boards on an annual basis.

Interpretation

52. Where there is doubt as to the applicability or interpretation of the RJC's terms of reference and operating arrangements, the Chair of the RJC, with advice from the nominated Governance Advisor, shall have the final say, provided that the decision does not conflict with rights, liabilities or duties as prescribed by law.

Confidential information

53. Where confidential information is presented to the RJC all attendees will ensure that they treat that information appropriately considering any confidentiality requirements and information governance principles.

Openness and Transparency

54. As far as is practicably possible and appropriate, the RJC will meet in public to promote openness and transparency. A public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on each Health Boards website, where the papers supporting the public part of the agenda will be available.

	55. There will be occasions when some of the RJC's business is more appropriately considered in private session; this is to ensure that any business considered is not prejudicial to public interest, commercial sensitivities and data protection. **56.** The final decision on whether business should be discussed in private or public session shall be made by the RJC Chair, having taken advice from the nominated Governance Advisor.
Conflicts of interest	**57.** Conflicts of interest will be managed in accordance with relevant policies and procedures and shall be consistent with the three health boards' respective statutory duties and applicable national guidance. **58.** Where individual RJC members identify an interest in relation to any aspect of RJC business set out in the meeting agenda, that member must declare an interest at the start of the meeting. RJC members should seek advice from the Chair before the start of the meeting if they are in any doubt as to whether they should declare an interest at the meeting. **59.** All declarations of interest made at a meeting must be recorded in the Joint Committees minutes. **60.** It is the responsibility of the Chair, on behalf of the RJC, to determine the action to be taken in response to a declaration of interest declared. Where the Joint Committee Chair declares a personal interest, any decision on the action to be taken shall be made the Vice-Chair designated for that meeting.
Disputes	**61.** Where a dispute arises between the three health boards, which is connected to the operation of the RJC and its work, this shall be resolved in accordance with the dispute resolution procedure at **Appendix B**.
Behaviours and Conduct	**62.** Members will be expected to behave and conduct business in accordance with: a) The policies, procedures and governance documents that apply to their respective Health Board. b) Any collectively developed procedures or codes. c) The Values and Standards of Behaviour Framework of NHS Wales. d) The Nolan Principles e) Agreed partnership principles. **63.** Members must demonstrably consider equality diversity and inclusion implications of the decisions they make. **64.** Within the constraints of these Terms of Reference, RJC Members will act in the best interests of the population of the south-east Wales region, rather than representing the individual interests of an individual health board.

Reporting Arrangements	**65.** A copy of the meeting minutes of each meeting of the RJC, along with a summary report, shall be shared with the three Health Boards for information and assurance. The report shall set out matters discussed and pertinent issues, together with any recommendations and any matters which require disclosure, escalation, action or approval.
Review	**66.** The RJC will review its effectiveness at least annually on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference. The outcome of this will be included within the standing report to the three Health Boards set out in 65. **67.** These terms of reference, including membership and chairing arrangements, will be reviewed at least annually and more frequently if required. **68.** Any proposed amendments to these terms of reference will be submitted to the three Health Boards for approval.

APPENDIX A

SOUTH-EAST WALES REGIONAL JOINT COMMITTEE (RJC)

SCHEME OF DELEGATION AND RESERVATION OF POWERS

The tables below set out a Framework of Reservation and Delegations anticipated in respect of RJC business.

Unless explicitly set out within the RJC's Terms of Reference and this Framework, everything is retained by the three Health Boards respectively. Where Health Boards have delegated functions to the RJC, each Health Board shall be bound by the decisions of the Joint Committee in accordance with the Schedule of Powers delegated to the RJC

This Framework will be kept under active review and, where appropriate, will be revised to take account of developments, review findings or other changes.

A. MATTERS RELATING TO THE RJC, RESERVED FOR HEALTH BOARDS		
REF.	AREA	MATTER
A1.	Operating Arrangements	Approve the Joint Committee's Terms of Reference and Operating Arrangements (the Governance Framework for the RJC)
A2.	Strategy & Planning	Approve the annual priorities and programme of work for regional developments, as recommended by the RJC
A3.	Strategy & Planning	Approve a Regional Commissioning Strategy, if recommended by the RJC, for inclusion in Health Board Integrated Medium-Term Plans
A4.	Strategy & Planning	Approve the overarching financial commitment and financial framework required to enable delivery of the priorities set for the RJC (A2 and A3)
A5.	Strategy & Planning	Approve Capital and Revenue Business Cases (prior to WG approval if required), within the framework of: • The agreed annual priorities and programme of work for regional developments (A2) • The agreed Regional Commissioning Strategy (A3) • The overarching financial commitment and financial framework required to enable delivery of the priorities set for the RJC (A4)
A6.	Strategy & Planning	Approve the commencement of formal engagement and consultation on significant service change proposals
A7.	Strategy & Planning	Approve significant service change proposals for implementation

B. MATTERS RELATING TO THE RJC, DELEGATED FROM HEALTH BOARDS AND RESERVED FOR THE JOINT COMMITTEE		
REF.	AREA	MATTER
B1.	Operating Arrangements	Develop, vary, and amend the Joint Committee's Terms of Reference and Operating Arrangements (the Governance Framework for the RJC) for Health Board approval
B2.	Operating Arrangements	Develop and Approve the Terms of Reference and Operating Arrangements for the following which are deemed necessary to support the RJC in the exercise of its functions:

		• Programme and Project Governance – Established to provide a framework for managing and controlling programmes and projects. • Expert Panels – Established to review and make technical recommendations on specific subjects which generally consist of experts with relevant knowledge and experience within a particular field. • Advisory Groups – Established to provide advice over an issue/range of subject matters which generally consists of an external chair and internal and/or external stakeholders to make recommendations on a specific issue.
B3.	Strategy & Planning	Develop and approve, prior to Health Board approval, the annual priorities and programme of work for regional developments, in line with the RJC's purpose and responsibilities
B4.	Strategy & Planning	Develop and approve, prior to Health Board approval, a Regional Commissioning Strategy, for inclusion in Health Board Integrated Medium-Term Plans, where it is required
B5.	Strategy & Planning	Determine, for Health Board approval, the required financial commitment and financial framework to enable delivery of the priorities set for the RJC (A2 and A3)
B6.	Strategy & Planning	Approve Capital and Revenue Business Cases (prior to WG approval if required), within the framework of: • The agreed annual priorities and programme of work for regional developments (B3) • The agreed Regional Commissioning Strategy (B4) • The overarching financial commitment and financial framework required to enable delivery of the priorities set for the RJC (B5)
B6.	Strategy & Planning	Develop significant service change proposals which relate to regional developments, for Health Board approval
B7.	Strategy & Planning	Develop arrangements for the commencement of formal engagement and consultation on service change proposals, for Health Board approval
B8.	Performance & Assurance	Receive reports from Senior Responsible Officers on progress and performance in the delivery of the RJC's priorities and programme of work, and approve action required, including improvement plans where required
B9.	Performance & Assurance	Receive assurance reports from the RJC's sub-Committees and groups on the delivery of those delegated programmes of work
B10.	Performance & Assurance	Receive audit and review reports related to the work of the RJC (in addition to consideration through Health Boards)

C. MATTERS RELATING TO THE RJC, <u>DELEGATED FROM</u> THE JOINT COMMITTEE TO SUB-COMMITTEES, GROUPS AND OTHERS		
REF.	AREA	MATTER
		To be determined upon establishment of the RJC

APPENDIX B

SOUTH-EAST WALES REGIONAL JOINT COMMITTEE (RJC)

PROCESS FOR DISPUTES AND ARBITRATION

1. In accordance with the Terms of Reference for the RJC, Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Heath Board (the Health Boards) will seek to work cooperatively with each other as constituent members of the RJC and with the RJC as a whole. Where there is an impasse which cannot be resolved by means of conciliation between appropriate individuals, then as a last resort the following process should be followed.

2. In the event of any dispute between Health Boards relating to RJC business, all parties involved in the dispute must try to reach an agreement. This will involve meeting to discuss and trying to resolve the issues. All reasonable efforts must be made before escalating any disputed issues.

3. If a dispute cannot be resolved in accordance with the provisions of paragraph 2, the respective Health Board Chief Executive should have a further meeting with the two other Chief Executives of the RJC to determine if the matter can be resolved in-line with the partnership principles agreed within the RJC's Terms of Reference.

4. If a dispute cannot be resolved in accordance with the provisions of paragraph 3, the respective Health Board Chair should have a further meeting with the two other Health Board Chairs to determine if the matter can be resolved in-line with the partnership principles agreed within the RJC's Terms of Reference. The Health Board Chairs may wish to engage their respective wider Boards on this matter.

5. If a dispute still cannot be resolved in accordance with the provisions of paragraph 5, it shall be referred to the Welsh Government Director General for Health and Social Services and ultimately onwards to the Cabinet Secretary for Health and Social Services for resolution.

Agenda Item
7.3

Joint Commissioning Committee

Reservation of Powers and Scheme of Delegation

Dyddiad y Cyfarfod / Date of Meeting	01/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public
Awdur yr Adroddiad / Report Author	Stacey Taylor, Director of Finance & Value Jacqui Maunder, Committee Secretary
Cyflwynydd yr Adroddiad / Report Presenter	Stacey Taylor, Director of Finance & Value Jacqui Maunder, Committee Secretary
Noddwr yr Adroddiad / Report Sponsor	Chief Commissioner

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt /consideration at Committee/Group)		
Committee/Group/Individuals	**Date**	**Outcome**
NHS Wales Joint Commissioning Committee meeting Senior Leadership Team (SLT)	20 May 2025 7 May 2025	Approved Endorsed Endorsed

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf University Health Board
HA	Hosting Agreement
HB	Health Board
MOA	Memorandum of Agreement
NWJCC	NHS Wales Joint Commissioning Committee
SO	Standing Orders
SFI	Standing Financial Instructions

1. SITUATION/BACKGROUND

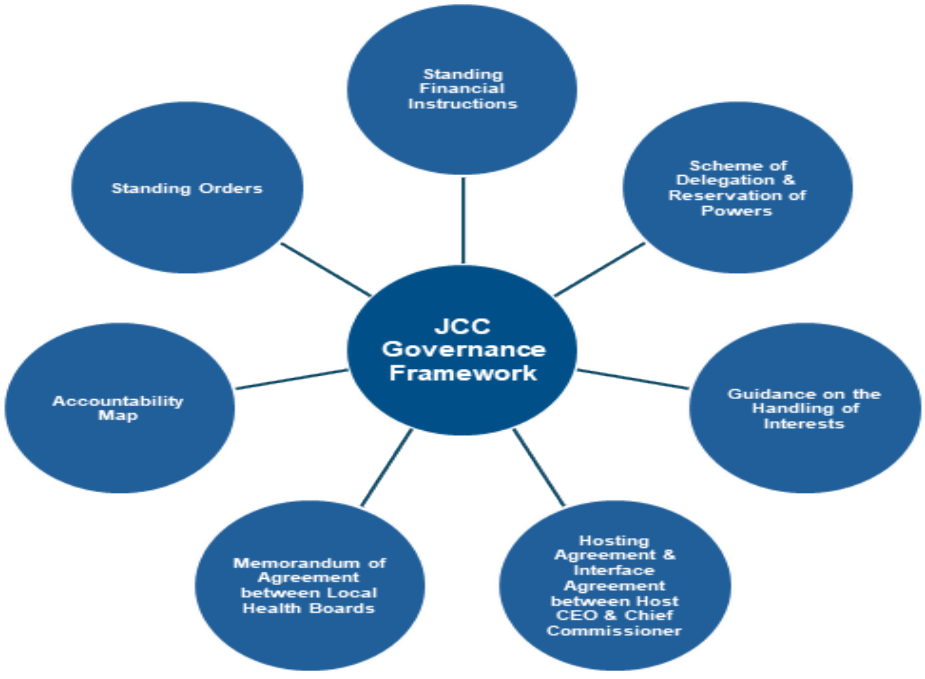
The purpose of this report is to request that the Board approves the updated Scheme of Delegation and Reservation of Powers for the matters further delegated from the NHS Wales Joint Commissioning Committee (NWJCC) to the Chief Commissioner (and other Officers as appropriate) as a schedule to the Health Board's (HB) Standing Orders.

Noting that the NWJCC approved the Scheme of Delegation and Reservation of Powers, for adoption, at its meeting on 20 May 2025.

1.1 GOVERNANCE FRAMEWORK FOR THE NHS WALES JOINT COMMISSIONING COMMITTEE

The Governance Framework for the NWJCC contains a number of key components which, combined, set out the legislative framework, constitution and ways of working for the NWJCC in its operations and handling of business. These documents are an integral part of the wider governance framework of Health Boards and have been developed within that context.

The Governance Framework for the NWJCC will contain the following and an update on each element is provided below:



Section 4 of the NWJCC Standing Orders (SOs) stipulates that the Joint Committee may make arrangements for certain functions to be carried out on its behalf, so that the day-to-day business of the Joint Committee may be carried

out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Joint Committee must set out clearly the terms and conditions upon which any delegation is being made. The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

- Schedule of matters reserved to the Joint Committee;
- Scheme of delegation to joint sub-Committees and others; and
- Scheme of delegation to the Chief Commissioner and others as appropriate all of which must be formally adopted by the Joint Committee and approved by LHB Boards as a schedule to their own SOs.

The Joint Committee retains full responsibility for any functions delegated to others to carry out on its behalf.

Each of the seven Health Boards are required to formally adopt the NWJCC's SOs, Scheme of Delegation and Reservation of Powers, and Standing Financial Instructions (SFIs), as part of its overall governance framework for the HB, with the NWJCC being a formal Joint Committee.

Joint Committee Meeting	Governance Document
9 April 2024	**1.Standing Orders** **2.Standing Financial Instructions,** **3.Scheme of Reservation and Delegation of Powers and** **4. NWJCC Transitional Delegated Financial authorisation matrix** The seven HBs approved the NWJCC SOs, the Scheme of Reservation and Delegation of Powers and SFIs in March 2024, and the Joint Committee adopted the NWJCC Standing SO's, the Scheme of Reservation and Delegation of Powers and SFIs at its inaugural meeting on 8 April 2024, and they were included as a schedule to each of the HBs own SOs and have effect as if incorporated within them. The Joint Committee also approved the NWJCC Transitional Delegated Financial authorisation matrix. It was recognised that the Scheme of Reservation and Delegation of Powers and the NWJCC Transitional Delegated Financial authorisation matrix would need to be updated further during the transition phase to reflect developments concerning delegated matters to the NWJCC, the Chief Commissioner, Directors and the new sub-committees once established.

Joint Committee Meeting	Governance Document
9 April 2024	**1.Accountability Map and** **2.Guidance on the Handling of Interests** The Accountability Map outlining the formal accountabilities and formal relationships between Welsh Government, Health Boards, Cwm Taf University Health Board (CTMUHB) as the Host Body, the NWJCC and its Team; and the Guidance on the Handling of Interests which sets out the arrangements for the appropriate handling of declarations of interests within the NWJCC's business, were both received by the Joint Committee at its inaugural meeting on 8 April 2024.
17 September 2024	**1.The Hosting Agreement (HA) and** **2.Memorandum of Agreement (MoA)** The Hosting Agreement (HA) and the Memorandum of Agreement (MoA) were endorsed by the Joint Committee on 17 September 2024 and were approved by the seven HBs at their September 2024 Board meetings. The Joint Committee were advised that work was ongoing during the transition phase to finalise the last part of the governance framework namely updating the Scheme of Reservation and Delegation of Powers.
20 May 2025	**Joint Commissioning Committee Scheme of Reservation and Delegation of Powers** The Joint Committee approved the adoption of the updated Scheme of Delegation and Reservation of Powers for the matters further delegated from the NWJCC to the Chief Commissioner (and other Officers as appropriate) all of which must be formally adopted by the Joint Committee and approved by HBs as a schedule to their own SOs, and reviewed and approved the updated financial scheme of delegation and the financial authorisation limits.

2.ASSESSMENT

2.1 Scheme of Delegation and Reservation of Powers

The NWJCC's Scheme of Reservation and Delegation of Powers forms an annex to the NWJCC's SOs, which form a schedule to each HBs own SOs and have effect as if incorporated within them. The Scheme of Delegation and Reservation of Powers, sets out in the context of the NWJCC's business:

- Those matters reserved for HBs;
- Those matters delegated from HBs and reserved for the NWJCC; and
- Those matters further delegated from the NWJCC to the Chief Commissioner (and other Officers as appropriate).

The Scheme of Reservation and Delegation of Powers is set out in two parts. The first part is the Schedule of Matters Reserved to the HBs and the Joint Committee see ***Appendix 1*** which is prescribed by Welsh Government; the second part is the Scheme of Delegation to the Chief Commissioner, Corporate Directors and Officers. Section 6.15 of the NWJCC SOs state:

"The JCC will delegate certain functions to the Chief Commissioner. For these aspects, the Chief Commissioner, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Commissioner will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers. (SO 6.15)"

In addition to the responsibilities delegated from the NWJCC, the Chief Commissioner will have delegated responsibilities from the Host Body (set out within the Hosting Agreement) and delegated responsibilities from Welsh Government (set out within an Accountable Officer Memorandum).

It is also necessary for the Host Body to confirm within its respective Scheme of Delegation and Reservation of Powers any functions delegated to the Chief Commissioner and the NWJCC team as the employer and provider of administrative (e.g. finance, workforce) services.

For completeness a mapping exercise has been undertaken to capture all of the delegations into one document, which is presented as the Scheme of Reservation and Delegation of Powers to the Chief Commissioner see ***Appendix 2.*** This includes delegations to the NWJCC, the Chief Commissioner and Tier 2 Directors.

2.2 Financial Authorisation Matrix Limits

The NWJCC's SFIs form an annex to the NWJCC's SOs, which form a schedule to each HB's own SOs and have effect as if incorporated within them. They are designed to translate statutory and Welsh Government financial requirements for the NHS in Wales into day-to-day operating practice. These SFIs will align with the NWJCC's Scheme of Delegation and Reservation of Powers and also be underpinned by an operational Scheme of Delegation which provides delegated authorisation levels and other delegated responsibilities in respect of financial management and control.

The SFIs were approved by the NWJCC at its meeting on 20 May 2025.

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC **Link to JCC Strategic Objectives(s)**	Maximise Value
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 (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Leadership
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Effective
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / **Quality** Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	
Cydraddoldeb Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / **Equality** Have you undertaken an Equality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	A Regulatory Impact Assessment is contained with the Explanatory Memorandum to The National Health Service Joint Commissioning Committee (Wales) Regulations 2024.
Cyfreithiol / Legal	Section 4.2 of the NWJCC SOs state: Reservation and Delegation of Joint Committee Functions 4.2 Within the framework approved by each LHB Board and set out within these JCC SOs and subject to any directions that may be given by the Welsh Ministers; the Joint Committee may make arrangements for certain functions to be carried out on its behalf, so that the day-to-day business of the Joint Committee may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Joint Committee must set out clearly the terms and conditions upon which any delegation is being made. 4.3 The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a) Schedule of matters reserved to the Joint Committee b) Scheme of delegation to joint sub-Committees and others, and c) Scheme of delegation to the Chief Commissioner and others as appropriate all of which must be formally adopted by	

	the Joint Committee and approved by LHB Boards as a schedule to their own SOs. 4.4 The Joint Committee retains full responsibility for any functions delegated to others to carry out on its behalf.
Enw da / Reputational	There is no direct impact on the reputation of the Local Health Boards or the Joint Committee 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.
	There is not expected to be an additional cost associated with the proposal in this report. Determining and approving the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure) is reserved to the Joint Committee and the Chief Commissioner.

3. RECOMMENDATIONS

The Board are asked to:

- **Note** the development of the NWJCC's governance framework, as a key component of the Health Board's governance framework;
- **Note** that the Joint Committee approved the adoption of the updated Scheme of Delegation and Reservation of Powers on 20 May 2025;
- **Approve** the adoption of the updated Scheme of Delegation and Reservation of Powers for the matters further delegated from the NWJCC to the Chief Commissioner (and other Officers as appropriate) all of which must be formally adopted by the Joint Committee and approved by LHB Boards as a schedule to their own SOs.

GIG CYMRU NHS WALES | Cyd-bwyllgor Comisiynu Joint Commissioning Committee

NHS WALES JOINT COMMISSIONING COMMITTEE

SCHEME OF DELEGATION AND RESERVATION OF POWERS

A. MATTERS RELATING TO THE JCC, RESERVED FOR HEALTH BOARDS		
REF.	AREA	MATTER
A1.	Operating Arrangements	Approval of the Joint Committee's Governance Framework, including: • JCC Standing Orders • JCC Standing Financial Instructions • JCC Scheme of Delegation and Reservation of Powers • JCC sub-Committee Terms of Reference
A2.	Strategy & Planning	Endorse the long-term strategic plan for the development of those functions delegated to the NHS Wales Joint Commissioning Committee (the Joint Committee), as agreed by the Joint Committee
A3.	Strategy & Planning	Endorse the JCC Integrated Medium-Term Plan, as agreed by the Joint Committee for inclusion in LHB Integrated Medium-Term Plans
A4.	Strategy & Planning	Endorse the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure), as agreed by the Joint Committee

B. MATTERS RELATING TO THE JCC, DELEGATED FROM HEALTH BOARDS AND RESERVED FOR THE JOINT COMMITTEE		
REF.	AREA	MATTER
B1.	Operating Arrangements	Develop, vary, and amend the Joint Committee's Governance Framework for LHB approval, including: • JCC Standing Orders • JCC Standing Financial Instructions • JCC Scheme of Delegation and Reservation of Powers • JCC sub-Committee Terms of Reference
B2.	Operating Arrangements	Develop and approve arrangements for the handling of Interests declared by Joint Committee members, in alignment with the Host Body's Values and Standards of Behaviour Framework
B3.	Operating Arrangements	Develop and approve the Terms of Reference and Operating Arrangements for the following which are deemed necessary to provide the JCC with advice in the exercise of its functions: • Expert Panels – Established to review and make technical recommendations on specific subjects which generally consist of experts with relevant knowledge and experience within a particular field. • Advisory Groups – Established to provide advice over an issue/range of subject matters which generally consists of an external chair and internal and/or external stakeholders to make recommendations on a specific issue.
B4.	Strategy & Planning	Develop and approve the long-term strategic plan for the development of those functions delegated to the NHS Wales Joint Commissioning Committee (the Joint Committee)
B5.	Strategy & Planning	Develop and approve the JCC's Integrated Medium-Term Plan, for LHB approval
B6.	Operating Arrangements	Ratify any urgent decisions taken by the Chair, in-line with JCC Standing Order requirements

B7.	Operating Arrangements	Receive report and proposals, after consideration by the appropriate Audit Committee, regarding any non-compliance with JCC Standing Orders (and schedules contained within), and where required ratify in public session any action required in response to failure to comply with JCC SOs for onward reporting to LHBs
B8.	Operating Arrangements	Adopt the Host Body's Values and Standards of Behaviour Framework for the JCC
B9.	Strategy & Planning	Determine and approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
B10.	Operating Arrangements	Approve the Joint Committee's Risk and Assurance Framework, ensuring alignment with the Host Body
B11.	Operating Arrangements	Approve the Joint Committee's Performance Management Framework
B12.	Performance & Assurance	Receive reports from the Chief Commissioner on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans
B13.	Performance & Assurance	Receive assurance reports from the Joint Committee's sub-Committees and groups on the performance of those services commissioned by the JCC, and approve action required, including improvement plans, where required
B14.	Performance & Assurance	Receive reports produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc.) that raise issue or concerns impacting on the Joint Committee's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Joint Committee sub-Committees (as appropriate)
B15.	Performance & Assurance	Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required
B16.	Performance & Assurance	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Commissioner, set out in the JCC's SFIs, and in-line with any requirements of the Host Body
B17.	Performance & Assurance	Approve the Joint Committee's audit and assurance arrangements, in-conjunction with the Host Body as the provider of an internal audit function
B18.	Performance & Assurance	Receive assurance regarding the Joint Committee's performance against the Health and Care Quality Standards 2023 and the Duty of Quality and the arrangements for approving required action, including improvement plans, to provide onward assurance to LHBs and the Host Body.
B19.	Strategy & Planning	Approve policies for the equitable access to safe and sustainable, high quality health care services across Wales for those services which fall within the scope of the JCC
B20.	Strategy & Planning	Approve the JCC's key plans and programmes required to exercise its functions relating to the planning, securing and commissioning of those services delegated to it (excluding the Integrated-Medium Term Plan [B5]).

C. MATTERS RELATING TO THE JCC, <u>DELEGATED FROM</u> THE JOINT COMMITTEE TO THE CHIEF COMMISSIONER		
REF.	AREA	MATTER
C1.	Performance & Assurance	Responsibility for the leadership and overall delivery of the JCC's: • Integrated Medium-Term Plan; and

		• Budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
C2.	Performance & Assurance	Responsibility for the framework for planning and securing those services delegated to the JCC from LHBs, in-line with the approved Integrated Commissioning Plan (title to be confirmed)
C3.	Performance & Assurance	Responsibility for ensuring the Health and Care Quality Standards 2023 and the Duty of Quality is embedded within Joint Committee Team's activity
C4.	Performance & Assurance	Responsibility for implementing those policies approved by the JCC in relation to the planning and securing of those services delegated to the JCC from LHBs

D. MATTERS RELATING TO THE JCC, <u>DELEGATED FROM</u> THE JOINT COMMITTEE TO SUB-COMMITTEE AND OTHERS (INCLUDING INIDVIDUAL LAY MEMBERS)		
REF.	AREA	MATTER
		To be determined upon establishment of the JCC

	Welsh Government / Chief Executive of NHS Wales	NWJCC	Joint Committee Chair	CEO Host Body and host body committees	Chief Commissioner	Deputy Chief Commissioner and Director of Finance and Value	Director of Commissioning for Ambulance and 111 Services	Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups	Director of Commissioning for Specialised Services	Medical Director	Director of Nursing and Quality	Director of Corporate Planning and Strategy	Committee Secretary and Assistant Director of Corporate Services
Welsh Government Ministers and CEO NHS Wales													
NHS Wales JCC Directions WG24-06 (to health boards to establish a joint committee to exercise the relevant functions)	√												
NHS Wales JCC Regulations 2024 no 135 (W29)	√												
Accountable officer status from WG to Chief Commissioner (letter and memo)	√				√								
Role of the JCC (SO 2.20)													
Determine a **long-term strategy for the commissioning of services delegated to the JCC**		√			√								
Produce an **Integrated Medium-Term Plan** which describes how these services will be delivered on behalf of LHBs through clear 'commissioning intentions' which informs and compliments the LHBs Integrated Medium-Term Plans (IMTPs)		√			√							Lead	
In commissioning services, the JCC will act in accordance with the Directions and Scheme of Delegation of the health boards		√			√								Lead
Identify and evaluate existing, new and emerging services and treatments and advise on the way in which these services should be delivered		√			√					Lead			
Develop policies (service specifications) for the equitable access to safe and sustainable, high quality health care services across Wales for those services which fall within the scope of the JCC (see line 35)		√			√					Lead			
Determine annually those services that should be commissioned on a regional or national basis		√			√								
Determine the appropriate level of funding for the commissioning of directed and delegated services at a regional or national level and determine the contribution from each LHBs for those services (which will include the running costs of the JCC and the Joint Commissioning Team) in accordance with any specific directions set by the Welsh Ministers		√			√	Lead							
Secure the provision of services delegated at a regional and national level including those to be delivered by providers outside of Wales		√			√								
Ensure the JCC operates within an appropriate governance framework.		√			√								Lead
Matters delegated from HBs and reserved for JCC													
Develop, vary, and amend the Joint Committee's Governance Framework for LHB approval, including: •JCC Standing Orders •JCC Standing Financial Instructions •JCC Scheme of Delegation and Reservation of Powers •JCC sub-Committee Terms of Reference (B1)	Accountable for model SOs and SFIs	√		Responsible for inclusion in CTMUHB and all HBs SOs and SFIs									Lead
Develop and approve arrangements for the handling of Interests declared by Joint Committee members, in alignment with the Host Body's Values and Standards of Behaviour Framework (B2)		√			√								Lead
Develop and approve the Terms of Reference and Operating Arrangements for the following which are deemed necessary to provide the JCC with advice in the exercise of its functions: •Expert Panels – Established to review and make technical recommendations on specific subjects which generally consist of experts with relevant knowledge and experience within a particular field. •Advisory Groups – Established to provide advice over an issue/range of subject matters which generally consists of an external chair and internal and/or external stakeholders to make recommendations on a specific issue. (B3)		√			√								Lead
Develop and approve the long-term strategic plan for the development of those functions delegated to the JCC (B4)		√			√							Lead	
Develop and approve the JCC's Integrated Medium- Term Plan, for LHB approval B5		√			√							Lead	
Ratify any urgent decisions taken by the Chair, in- line with JCC SOs (B6)		√	√		√								Lead
Receive report and proposals, after consideration by the appropriate Audit Committee, regarding any non- compliance with JCC Standing Orders (and schedules contained within), and where required ratify in public session any action required in response to failure to comply with JCC SOs for onward reporting to LHBs (B7)		√			√								Lead
Adopt the CTMUHBs Host Body's Values and Standards of Behaviour Framework for the JCC (B8)		√		Responsible for Values and Standards of Behaviour Framework	√								Lead
Determine and approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure) (B9)		√			√	Lead							
Approve the JCC's Risk and Assurance Framework, ensuring alignment with the Host Body (B10)		√			√								Lead
Approve the JCC's Performance Management Framework (B11)		√			√	Lead							
Receive reports from the Chief Commissioner on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans (B12)		√			√							Lead	
Receive assurance reports from the JCC's sub-Committees and groups on the performance of those services commissioned by the JCC, and approve action required, including improvement plans, where required (B13)		√			√								Lead
Receive reports produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc.) that raise issue or concerns impacting on the JCC's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of JCC sub-Committees (as appropriate) (B14)		√			√								Lead
Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required (B15)		√			√							Lead	
Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Commissioner, set out in the JCC's SFIs, and in-line with any requirements of the Host Body (B16)		√		√	√	lead							
Approve the JCC's audit and assurance arrangements, in-conjunction with the Host Body as the provider of an internal audit function (B17)		√			√	co-lead							co-lead
Health and Care Quality Standards 2023 and the Duty of Quality and the arrangements for approving required action, including improvement plans, to provide onward assurance to LHBs and the Host Body. (B18)		√			√						Lead		
Approve policies (service specification) for the equitable access to safe and sustainable, high quality health care services across Wales for those services which fall within the scope of the JCC (B19)		√			√					Lead			
Approve the JCC's key plans and programmes required to exercise its functions relating to the planning, securing and commissioning of those services delegated to it (excluding the Integrated- Medium Term Plan [B5]) (B20)		√			√							lead	
Matters delegated by JCC to CC - page 40 of SOs)													
JCC's: •Integrated Medium-Term Plan; and •Budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure) (C1 - matters delegated from the JCC to CC)					√	Lead						Lead	
Responsibility for the framework for planning and securing those services delegated to the JCC from LHBs, in-line with the approved IMTP / Foundation Plan (C2 - matters delegated from JCC to CC)					√							Lead	
Responsibility for ensuring the Health and Care Quality Standards 2023 and the Duty of Quality is embedded within Joint Committee Team's activity (C3 - matters delegated from JCC to CC)					√						Lead		
Responsibility for implementing those policies approved by the JCC in relation to the planning and securing of those services delegated to the JCC from LHBs (C4 - matters delegated from the JCC to CC)					√							Lead	
Committee secretary role (SO 6.16)													
Providing advice to the Joint Committee as a whole and to individual Committee members on all aspects of governance -Facilitating the effective conduct of Joint Committee business through meetings of the Joint Committee, its joint sub-Committees and Advisory Groups -Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role -Ensuring that Joint Committee members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs; -Ensuring that in all its dealings, the Joint Committee acts fairly, with integrity, and without prejudice or discrimination; -Contributing to the development of a committee culture that embodies NHS values and standards of behaviour; and -Monitoring the Joint Committee's compliance with the law, JCC SOs and the framework set by the LHBs and Welsh Ministers.				√								Lead	

The Committee Secretary is accountable to the Joint Committee Chair for all matters in relation to the responsibilities delegated in respect of the JCC's Governance Framework, within the context of the overarching Governance Framework of the 7 LHBs. The Committee Secretary is accountable to the Chief Commissioner for their performance as an employee of the Host Body and a member of the JCC Commissioning Team.			yes		√								Lead	
As a Joint Committee of LHBs, the Committee Secretary will have a relationship with the Directors of Corporate Governance of each of the 7 LHBs, in respect of the overarching governance framework of the 7 LHBs. As an employee of the Host Body (CTMUHB), the Committee Secretary will also have a relationship with the Host Body's Director of Corporate Governance with regard to the governance of those functions delegated to the JCC Team via					√								Lead	
Specifics														
The JCC will set out (SO 4.3): 1. Schedule of matters reserved to the Joint Committee 2. Scheme of delegation to joint sub-Committees and others 3. Scheme of delegation to the Chief Commissioner and others as appropriate all of which must be formally adopted by the Joint Committee and approved by LHB Boards as a schedule to their own SOs.		√												
Approve those policies relevant to the business of the Committee as delegated by the LHBs or the host Board (SO 5.1)		√			√							√		
The Joint Committee Chair will have a relationship with the Host Body's CEO given their respective accountability arrangements with regard to their role in holding a shared accountability for the Chief Commissioner (SO 5.4 more in Hosting Agreement			√	√	√									
The JCC will delegate certain functions to the Chief Commissioner. For these aspects, the Chief Commissioner, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Commissioner will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers. (SO 6.15)		√			√									
Lead on compliance with the Standing Financial Instructions				with DOF	√	Lead								
Lead on compliance with Standing Orders and the Governance Framework					√								Lead	
To fulfil its functions, the Joint Committee shall lead and scrutinise the operations, functions and decision making delegated to the Chief Commissioner and others undertaken at the direction of the Joint Committee (2.21).		√												
The Committee Secretary is accountable to the Joint Committee Chair for all matters in relation to the responsibilities delegated in respect of the JCC's Governance Framework, within the context of the overarching Governance Framework of the 7 LHBs. The Committee Secretary is accountable to the Chief Commissioner for their performance as an employee of the Host Body and a member of the JCC Commissioning Team. (SO 6.16)			√		√								Lead	
The Joint Committee Chair, in consultation with the Committee Secretary and the Chief Commissioner, will set the agenda. (SO 7.10)			√		√								Lead	
The Host Body's Standards of Behaviour Policy (Incorporating Declarations of Interest, Gifts, Hospitality, Sponsorship and Honoraria) applies to the Joint Committee's Chair, Lay Members and Chief Commissioner, and prohibits Joint Committee members from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way. (SOs 8.9)			√	√	√								√	
Agree Scheme of Delegation for JCC Team (reflecting SoD of JCC) and Approve Financial Limit for JCC Team Responsible Officers					√									
Determine JCC Team Annual Priorities					√									
Approve JCC Team Workplan (based on IMTP)					√									
Sign off DRAFT IMTP for submission to NWJCC prior to WG HSCEYG planning team		√			√									
Annual Review of Hosting Agreement				√	√									
Endorse amendments to any JCC Governance documents such as SOs, SFIs, Hosting Agreement, Memo of Agreement for approval at HBs		√			√								Lead	
Approve JCC Branding	√				√									
Sign off relevant reports/papers for Committees relating to professional area					√									
Approve draft annual operating budget for NWJCC		√			√									
Allocate annual budget allocation to relevant functions/programmes of the NWJCC		√			√	Lead								
Approve draft JCC Risk Register for reporting to the NWJCC					√									
Approve JCC staff engagement plan					√									
Approve JCC partnership and stakeholder engagement plan		√			√							Lead		
Approve appointment of Directors of JCC Team					√									
Approve appointment of Deputy Directors of JCC Team (in relevant professional area)					√	*								
Consider redundancy and Voluntary Early Release applications prior to submission to CTMUHB for approval noting WG approval required over £50k settlement				√	√	*								
Approve redundancy and Voluntary Early Release applications for submission to CTMUHB RATS noting WG approval required over £50k settlement				√	√									
Appraisal of Directors of the JCC Team					√									
Appraisal of Chief Commissioner RO in relation to compliance with Hosting Agreement			√	√	√									
Review ToRs for JCC SLT					√								Lead	
Approve ToRs for SLT					√									
Establish Sub Groups to report to SLT and agree ToRs					√								Lead	
Establish the Collaborative Commissioning Leadership Group					√								Lead	
Approve ToRs for CCLG					√									
Review JCC Team Operating Model and Structure to ensure fit for purpose					√	*								
Approve amendments to the JCC Team Operating Model and Structure					√	*								
Engagement of staff within funded establishment					√	√	√	√	√	√	√	√		
Engagement of staff outside funded establishment					√	√								
Approval of revised job resulting in change in grade in line with agreed policy and All Wales Terms and Conditions					√	√	√	√	√	√	√	√	√	
Approve & manage overtime, travel expenses, absence and leave within funded establishment (in accordance with CTMUHB Policies)					√	√	√	√	√	√	√	√	√	
Approval of mobile phones / IT equipment					√	√	√	√	√	√	√	√	√	
Management of allocated budgets					√	√	√	√	√	√	√	√	√	
Approval of in-year budget virements between Director Budgets					√									
Receive reports on progress against performance in delivery of the JCC Team Workplan					√									
Endorse Annual Report, Annual Governance Statement and Annual Quality Report of the JCC prior to submission to CTMUHB		√			√						Lead		Lead	
Approve JCC Annual Report, Annual Governance Statement & Annual Quality Report		√			√								lead	
Agree scope of planned internal audit		√			√	Lead							Lead	
Receive internal audit reports to develop management response		√			√	Lead	√	√	√	√	√	√	Lead	
Approve final internal audit reports		√			√	√								
Receive reports from external/independent parties for consideration and action where necessary		√			√									
Dismissal of staff (in accordance with delegations set out in CTM policy)				√	√	√	√	√	√	√	√	√	√	
Approval of legal action					√								Lead	
Approval of receipt of any gift, hospitality or sponsorship (of individuals) under CTM policy (NB Gifts above £25 should not be accepted; gifts over £25 where it is not possible to decline must be declared and seek approval; tickets to sporting events must not be accepted; all offers of gifts over £25 whether accepted or declined should be declared)					√								Lead	
Approval of receipt of sponsorship in line with CTMUHB policy http://ctuhb-intranet/dir/Corporate/Decs/GHSH/Spon/_layouts/15/start.aspx#/					√	√	√	√	√	√	√	√	Lead	
Approval of JCC Pulse Bulletin and information for publication					√									
Financial limits - See Financial Authorisation Matrix														
Payroll														
Payroll new starters					√	√	√	√	√	√	√	√	√	
Payroll leavers					√	√	√	√	√	√	√	√	√	
Establishment vacancy authorisation					√	√								
Payroll changes financial					√	√								
Payroll changes non financial e.g. financial coding					√	√	√	√	√	√	√	√	√	
Payroll travel expenses					√	√	√	√	√	√	√	√	√	
Payroll study leave					√	√	√	√	√	√	√	√	√	
Financial matters in line with additional delegations from the SFIs														
Funding releases (was WHSSC Management Group)					√	√			√					
Manage reserves and contingencies					√	√								
Manage and control of stocks					√	√							Lead	
Monitor and achievement of management cost targets					√	√								
Recording of payments under the losses and compensation regulations					√	√								
Issuing tenders and post tender negotiations					√	√								
Operation of detailed financial matters including bank accounts and banking procedures				with DOF of host body	√	√								
Corporate														
Information governance					√								Lead	with ctm
Management of concerns					√						Lead			
Lead on health and safety arrangements (not line management duties)					√							Lead		
Investigate any suspected cases of irregularity not related to fraud and corruption in accordance with Government directions					√	√								
Legal advice					√								Lead	
Action on litigation				with Director of Nursing	√								√	
Workforce				with Director of People host body	√								Lead	

Report Title:	Corporate Risk Register			Agenda Item no.	8.1
Meeting:	Board Meeting	Public	x	Meeting Date:	25th Sept 2025
		Private			
Status *(please tick one only)*:	Assurance x	Approval		Information	x
Lead Executive (**Title**):	Director of Corporate Governance				
Report Author (**Title**):	Corporate Archivist and Records Management Manager				

Main Report
Background and current situation:

The Corporate Risk Register ("the Register") has been developed to provide the Board with an overview of the key operational risks from the Clinical Boards and Corporate Directorates.

The Register includes risks which are rated 20 (out of 25) and above but, it may also include risks of a lower score when required to inform the Board of specific risks with the potential to affect the achievement of UHB strategic objectives.

The register can be located in the supporting documents folder on AdminControl and the Cardiff and Vale UHB website.

Our risk registers have traditionally been managed using an Excel spreadsheet. However, the Corporate Governance team is working to streamline and digitise this process across the Health Board by implementing a new Risk module within the AMaT (Audit Management and Tracking) system. As early adopters of this evolving module, we have had the opportunity to trial its functionality and participate in regular workshops to provide valuable feedback for system enhancements. These improvements will help create a more robust system for all Clinical Boards and Directorates.

In parallel, comprehensive project plans and implementation schedules have been developed in collaboration with the Shaping Change Team to ensure a smooth transition throughout the Health Board. Our goal is to make the transition as seamless and manageable as possible, while minimizing any impact on workloads.

As of the 1st August a Health Board wide Task and Finish Group was established. The aim of the group is to support the delivery of the Digital Risk project in the following areas: Data mapping, AMaT Training and the communication and rollout across the clinical boards and Directorates.

By supporting these areas, the task and finish group will ensure that the project is delivered in a timely manner and contribute to the UHB transferring from managing their risks in excel to the digital solution. Invitations to monthly meetings for the remainder of 2025 have been shared with all risk owners/representatives. First milestone target is the full transition of Corporate Register (Risks scoring 20 and above) to be saved and managed within AMaT by the end of Oct 25. Allowing for review and moderation by the Strategic Leadership Team during Nov 25.

Appendices (located in the suppporting documents folder):

1. Corporate Risk Register
2. CEF – Corporate Risk Register

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The Corporate Governance Team ("the Team") continue to work alongside Clinical Boards and Corporate Directorates to ensure that risks are clearly defined and appropriately scored in line with the Health Board's Risk Management and Board Assurance Framework Strategy and associated procedures.

The Team's predominant focus of support to Clinical Boards/Corporate Directorates has been to provide advice and guidance to risk leads/risk owners in their assessment and management of complex risks, and the refinement of their internal risk management processes. In addition, the Team continue to support requests from senior risk managers to deliver risk assessment and risk management training to their teams and newly appointed risk managers.

The Board should note that Clinical Board risks are also monitored and scrutinised at Monthly Clinical Board Review meetings. Clinical risk is addressed through the Clinical Safety Group governance framework.

The risks presented in the register can be viewed through a lens of cause and effect. There is an identifiable pattern from a cause perspective that predominantly falls into estate and infrastructure risks with a proportion that also fall under the umbrella of workforce. In line with monitoring the financial position, 2 new finance risks have been identified which have been incorporated into the Corporate Risk register

The Capital, Estates, and Facilities (CEF) risk register is now reported by discipline and has been introduced so that risks can also be identified in general terms, due to volume these are now provided in a separate appendix. CEF have fully transitioned their Corporate level risks to AMaT and the new Excel layout is a result of this transition.

The Director of Corporate Governance continues to review the risk register in order to establish a coherent structure of risk moderation and engagement across the Health Board. Work is ongoing to work with Clinical Boards and other areas to refine the risk register in parallel to Clinical Board reviews etc.

Summary of key updates within Sept 2025 Risk Register

Board/Directorate	Info
Capital Estates & Facilities (CEF)	All Corporate risks now reported via AMaT Please review Appendix 2 for increased data transparency and scoring rational

ASSURANCE is provided by:

- Ongoing discussions with Clinical Boards and the Corporate Directorates regarding the scoring of risk.
- The presence of risk registers in CB and Corporate planning functions e.g. Capital and Investment decisions.
- The programme of education and training that is being implemented by the Corporate Governance team to ensure that the Health Board's Risk Management policy is engrained and followed within Clinical Boards and Corporate Directorates.
- Increasing routine dialogue on risk issues between Clinical Board/Corporate Directorate Risk Leads and the Team.
- The Reasonable Assurance rating provided by Internal Audit for the Health Board's Risk Management processes.
- Mapping of risk across departments and directorates and aligning it to the evolving strategy and planning work.
- Introduction of digitalised platform to track and manage all risks ratings providing increased awareness and transparency through dashboards and data reports.

Recommendation:

The Board is requested to:

Note the Corporate Risk Register and the work in this area which continues to progress.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please place an "X" in the below boxes as relevant.*			
1. Putting People First **Click the objective above to view more detail.**	X	Providing Outstanding Quality **Click the objective above to view more detail.**	X
3. Delivering in the Right Places **Click the objective above to view more detail.**	X	Acting for the Future **Click the objective above to view more detail.**	X

Five Ways of Working (Sustainable Development Principles) considered ***Please place an "X" in the below boxes as relevant***									
Prevention	X	Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed? *Please place an "**X**" in the below boxes as relevant. A blank QIA and guidance on how to complete a QIA can be found by clicking the link here:* ***Quality Impact Assessment Information***				
Yes – (***please provide completed QIA document***)	X	No – ***(Please provide reasoning, e.g. not required)***	X	*Not required*

Impact Assessment: *Please state **yes** or **no** for each category.* ***If yes please provide further details.***
Risk: Yes
The management and maintenance of the Health Board's Corporate Risk Register contributes to the Health Board's Risk Management processed and procedures.
Safety: No
Financial: /No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

Saunders,Nathan
21/09/2025 15:54:19

CORPORATE RISK REGISTER SEPT 2025

Clinical Board/ Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating: Consequence	Initial Risk Rating: Likelihood	Initial Risk Rating: Total	Controls	Current Risk rating: Consequence	Current Risk rating: Likelihood	Current Risk rating: Total	Actions	Target Risk rating: Consequence	Target Risk rating: Likelihood	Target Risk rating: Total	Date of next review	Assurance Committee	Link to BAF
Clinical Diagnostic & Therapeutics	Clinical Diagnostics & Therapeutics/2025-2602	26/08/2025	Non-Compliance with Regulatory and Accreditation Requirements There is a risk that regulated areas in the Clinical Board report non-comprinace with regulatory and accreditation requirements. This is caused by non-compliance in meeting the standards required by regulatory bodies following inspections and assessments. "Which could lead to an impact/effect on: - impact on service delivery and patient safety (potential for cease and desist of service) - reputational risk - financial risk e.g. loss of income, fine for breach of statutory duty - inability to maintain suitable systems, practices and facilities to ensure on-going compliance - increasing requirements from regulators which cannot be met - mismatch in capacity/demand on QMS which leads to failure to deliver activities - patient/staff harm as a result of poor safety governance, e.g. ultrasound, MR safety, decontamination, POCT - Health and Safety at Work incidents - patient concerns, claims and redress - failure to comply with GDPR and Information Governance"	Catastrophic	Highly Unlikely	20	Governance through QSE and Regulatory Compliance Group with Clinical Board oversight of regulated and accredited services. Incident management, including Root Cause Analysis Concerns management Audit of practice/standards risk register management Service improvement initiatives Clinical Board Data Integrity Policy and Assessment Standardised QMS approach between directorates Dedicated quality resource in key directorates	Major	Almost Certain	20	Compliance dashboard developed to monitor KPI/metrics Q-Pulse/local audit Locally replicated QSE structures with escalation triggers Monitoring of non-conformance/action plans through QSE and Regulatory Compliance Group Suitable forums Suitable forums for monitoring governance compliance Assessment against Healthcare Standards Ultrasound governance Group re-established	Minor	Almost Certain	10	Review date: 01/11/2025 Review date: 01/10/2025	Clinical Board Q&S Meeting Clinical Board Review QSE Committee	
	Clinical Diagnostics & Therapeutics/2025-2603	27/08/2025	IT/digital risks linked to hardward and software There is a risk that services are being compounded by hardware and software issues and slow delivery of key IT systems This is caused by ageing hardware and software, ongoing stability issues with WCCIS, WLIMS, TrakCare, Telepath and connectivity issues with POCT devices and electronic requesting within the Radiology Information System's inability to address patient identification issues. Which could lead to an impact/effect on mulitple workstreams with digital agenda not being aligned/inconsistently implemented; inability of PARIS system to interface with the Welsh Clinical Portal and Electronic requesting within RADIS only available for GP and inpatients and not for Outpatients.	Catastrophic	Highly Unlikely	20	Robust business continuity plans Workarounds to mitigate risks SOPs/governance arrangements Engagement with DHCW ETR/GPTR mandated from July 2022 Communication with end users Managed service contracts Maintenance service agreements	Major	Almost Certain	20	Validation and change controls. Enhanced monitoring arrangements	Moderate	Highly Likely	12	Review date: 01/11/2025 Review date: 01/10/2025	Clinical Board Q&S Meeting Clinical Board Review Digital Health Intelligence Directorate Q&S meeting	
	Clinical Diagnostics & Therapeutics/2025-2605	08/09/2025	Ageing equipment across the CD&T Clinical Board There is a risk that Ageing equipment will fail, including Air handling units, chiller units, air tube for lab specimens, pharmacy isolators and autoclaves, laboartory equipment and CT2 scanner This is caused by ageing equipment Which w/could lead to an impact/effect on temperature sensitive equipment, timely delivery of specimens to the laboratory, ability to make 700 doses of pre filled syringes, lack of sterility to products, dleays in laboratory processes and delays to patients receiving timely CT scans and thus diagnosis	Catastrophic	Highly Unlikely	20	capital management programme, discretionary capital programme, escalaion routes to CEF, business continuity plans, managed service contracts, maintenance agreements, medicla equipment governance framework	Catastrophic	Highly Likely	20	Inspections and audits, trend and theme analysis from incidents, validation and change control processes. Enhanecd monitoring arrangements	Major	Unlikely	8	Review date: 30/10/2025	Clinical Board Q&S Meeting	
	N&D/2023-2402	24/04/2023	Supply issues with metabolic dietary products There is a risk that supply Issues with metabolic dietary products could result in irreversible risk to health and enteral products in community This is caused by inability to predict when there willl be supply issues and no control over suppliers being able to honour prescriptions. Which w/could lead to an impact/effect on patients if samples are not available due to national shortages and delivery companies not advising dietititians which patients are affected.	Catastrophic	Highly Unlikely	20	Nutricia update IMD dietitians weekly on known supply issues and suggested alternatives via a live document IMD Dietitians ask patients at clinic appointment whether they have any product stock / supply issues Small stock of certain metabolic nutritional products kept in the UHW dietetic department	Catastrophic	Highly Likely	20	IMD company reps to urgently send product samples if they have stock. Adult and Paediatric Log of reported issues. Senior IMD Dietitians involved in the process of recommending clinically appropriate alternatives where available. DAPs check progress of alternative prescription request / samples. Product company to contact dietitians to update which patients are affected and what is being provided as an interim."	Catastrophic	Unlikely	10	Review date: 31/10/2025	Clinical Board Q&S Meeting Directorate Q&S meeting	
	Clinical Diagnostics & Therapeutics/2025-2606	12/09/2025	Fabric of the estate is suboptimal to deliver modern, safe and sustainable health care "There is significant aggregated risks across the CB directorate riks registers including: Inadequate accommodation for stem cell processing unit, risk of compressor failures and liquid nitrogen supply from external tanks Inadequate storage capacity across health records, risk to security of records, increased costs of off site storage and difficulties in tracking medical records Overcrowded accommodation for clinical engineering, OT, SLT, Pharmacy, POCT, WEQAS, CEDAR impacting on staff experience Repeated examples of water and sewage ingress into clinical and non clinical areas, risk to service delivery and staff health and safety Potential of electrical supply to UHL failing with delays to back up supply or fluctauations leading to insufficient time to power down CT scanner, risking costly damage to the collimator and associated downtime leading to loss of clinical activity" This is caused by ageing infrastructure Which w/could lead to an impact/effect on service delivery, health and safety of colleagues working in subotimal environments	Catastrophic	Highly Unlikely	20	Capital planning programme Discretionary capital programme Escalation routes to Estates Business Continuity Plans Managed service contracts Maintenance service agreements	Catastrophic	Highly Likely	20	Inspections and audit Risk register Trend and theme analysis from incidents Validation and change control Enhanced monitoring arrangements	Major	Unlikely	8	Review date: 01/11/2025	Clinical Board Q&S Meeting	
	Clinical Diagnostics &	/2025	Delay to laboratory information system (LIMS) implementation "There is a risk that Laboratory information system, migration from TLC2016 to TCLE. If TCL2016 continues to operate past mid-December 2025, it presents significant operational, clinical and financial risk. - Financial - DHCW have estimated that the cost of passing the December deadline could amount to £6.5m nationally with the need to update the hosting infrastructure and licencing, and extension of the programme team. - Operational - Despite the infrastructure refresh, the TCL2016 system is end of life, and presents a greater risk of breakdown / disruption to service for which there would be minimal support from the supplier and inability to fix problems. - Clinical - Running the laboratories on an unsupported system presents significant clinical risk of unavailability of results for patient care. - Workforce - Extending the programme beyond December 2025 will exacerbate an already known workforce risk of burnout and retention. 2. Risk to achieving December deadline - Ongoing delays to the completion of UAT is causing the deployment schedule to be revised again and again. Currently there is a risk to Blood Sciences not achieving deployment before mid December due to the volume of work still left to be completed. - There is a risk that insufficient resource is available for this programme as it is way beyond its delivery date. Resources are having to be deployed on an ad -hoc basis from current workforce, in competition with operational demands. Drafting in expertise from elsewhere is not an option as it doesn't exist. This is placing a significant burden on the laboratory teams, with risk to well-being of burnout, engagement and retention. -The lack of confirmed deployment dates due to the ongoing uncertainties within UAT presents a risk in planning for deployment and potential for key staff to be on leave at crucial times	trophic	Unlikely	20	"1. Contingency plans for backup and alternative storage systems 2. Accelerate migration to TCLE	trophic	Likely	20	"1. Monitor storage configurations closely and conduct regular audits to assess	trophic	Unlikely	5	"Review date:	"Clinical Board Q&S Meeting Clinical Board	

CORPORATE RISK REGISTER SEPT 2025

Clinical Board/ Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
	Therapeutics/2025-2607	01/07	leave at crucial times). - Loss of experienced staff presents a risk to completion of the programme at Cardiff, notably Path IT lead, Quality and senior lab staff in Haematology. 3. TCLe MVP - The accelerated timescale of this programme necessitated acceptance of a minimum viable product. This means that some functionality of the existing system will not be available in TCLe. The level of workarounds to make this a viable product will compromise the efficiency of the laboratory processes, with the risk of being unable to process work in a timely way. 4. Legacy Data - The is a clinical concern around the legacy data for some disciplines. Although some data will be available in WCP, other information currently captured within TLC16 that is used by the laboratory staff before publishing results will no longer be readily available, with the expectation that requests are made via servicepoint to DHCW to produce ODBC extracts from TCL16 which is not feasible when it comes to patient care. This will lead to an increased number of tests being carried out on patient specimens for teams to be able to rebuild patient profiles and recapture information previously available to them. 5. Blood Transfusion - As the only system not currently on TCL16, this deployment is scheduled for sometime in Q4 2025/26. However, it carries the financial risk of extending the Telepath system. There is also a significant risk with legacy data migration due to the quality of historic data. Validation of this is delayed." This is caused by issues with completion of UAT Which w/could lead to an impact/effect on achieving December deadline, potential financial risk, disruption to the service, having to run laboratories on unsupported systems presents a clinical risk. The effect could alos be on staff burnout and retention	Catast	Highly	20	2. Accelerate migration to TCLe 3. Prioritise completing UAT for TCLE	Catast	Highly	20	2. Programme board developing robust monitoring plan to identify blockers.	Catast	Highly	9	31/10/2025	Review Digital Health Intelligence"	
Digital Health	CRR17	06/08/2011	Cyber Security - Due to prevailing national and international Cyber Security threats there is a risk that the Health Board's IT infrastructure could be compromised resulting in prolonged service interuption and potential impacts on the safety of patients due to an inability to access electronically stored data.	5	4	20	The UHB has in place a number of Cyber security precautions. These include the following: - The implementation of additional VLAN's and/or firewalls/ACL's - Segmenting and an increased level of device patching. - The use of Monitoring and Vulnerability Softare - Health Board wide Mandatory Cyber Security Training and Phishing Campaigns.	5	4	20	"January 2024 update: Cyber Security Manager now re-banded and currently being advertised. This new post will operational lead the Cyber team strengthen the UHB's cyber security posture. A further phishing simulation was launched in October to continue raising cyber security awareness. In February, we also promoted 'vishing' training to all staff. May 2024 update: New Cyber Security Lead appointed and due to start 14th May 2024. Priorities include further deployment of CAV assessment to assist with NISD compliance. July 2024 update: Progress made with developing a combined Information Asset Register and Business Impact Assessment to be sent out to all services. This will be used to centrally log all assets and identify and assess critical systems. The DR plan is also under review. Oct '24: Cyber team fully recruited and focused on updating the cyber action plan Jan'25: New Secure Web Gate Way currently being deployed across the organisaton to further secure our internet interface and provide the UHB better control. Mar 2025: New Secure Web Gateway has been fully deployed across the organisation, with all capable devices now using the new gateway, with few exceptions. This has provided much greater control over permitted websites, which can be used to manage/reduce website related security risks. It also works to prevent unauthorised users from installing systems without the knowledge of Cyber Security and/or the Service Desk teams. May 25: Two further phishing simulations performed. 97 users with very weak passwords reset. Gen AI guidance to be accepted by users before visiting AI sites. July 2025: Annual review of local admin accounts performed - 26 accounts disabled. High risks moved from Cyber Risk Register transferred to AMaT to provide a better risk management solution. Old RDS de-commissioned removing a large number of legacy servers."	5	3	15	Jul-25	Digital Health Intelligence	Capital Assets Digital Strategy and Road Map
EPRR	EPRR/2025-2602	03/02/2025	Risk - There is a significant risk of staff abscence severly impacting service provision Cause - Extremely small critical mass of specialist staff. EPRR team consists of only 2 whole time equivelants. Both have in excess of 40 years expert knowledge and experience across the NHS / HM Forces / Blue light organisations. Both post holders are close to retirement, however there is no sucsession planning. Highly specialist role which is not replicated by any other postholder within the UHB. Neighbouring UHBs has a larger establishment which affords a greater degree of security and resilience. Business cases to enhance establishment, promote resillience , facilitate sucession planning, have been repeatidly declined from 2014 - 2023 due to a stated lack of financial resources. Effect - Which would lead to the Health Board failing to meet and comply with its statatury duties	Major	Almost Certain	20	Highly specialist role which is not replicated by any other postholder within the UHB. Neighbouring UHBs has a larger establishment which affords a greater degree of security and resilience. Business cases to enhance establishment, promote resillience , facilitate sucession planning, have been repeatidly declined from 2014 - 2023 due to a stated lack of financial resources.	Major	Almost Certain	20		Moderate	Unlikely	6	Aug-25	Team Meeting Directorate Meeting	
	EPRR/2025-2604	03/02/2025	Lack of dedicated staff resource to effectivly embed business continuity planning within the organisation. Risk - There is a risk that business continuity planning within the organisation will not be effectivly embed. Cause - The team consists of only 2 whole time equivelants. Business continuity is one componenet of a far reaching portfolio, and represents 1 of the 7 statuatiry responsibilities under the Civil Contingencies Act (2004). Do not have the capacity to ensure BC is absolutely embedded within the UHB. Effect - The organisation fails to comply with its statury duties under the Civil Contingencies Act 2004	Major	Almost Certain	20	As above (EPRR 01), the team consists of only 2 whole time equivelants. Business continuity is one componenet of a far reaching portfolio, and represents 1 of the 7 statuatiry responsibilities under the Civil Contingencies Act (2004). The team can provide substantial assurance of Policy / Proceedure production ; the provision of training ; the facilitation of exercises ; promoting a clinical board BC lead forum. But do not have the capacity to ensure BC is absolutely embedded within the UHB.	Major	Almost Certain	20		Minor	Unlikely	4	Aug-25	Team Meeting Directorate Meeting	
	EPRR/2025-2603	12/03/2025	No provision for specialist EPRR advice or presenece outside normal office hours. Risk - There is a risk that specialist advice is not available during adverse events out of hours Cause - Historically this provision has been provided on a "good will" free of charge basis, and has not attracted the same financial reconpense afforded to other on call managers. The frequency of calls for advice, and both "stand by" and "Live" incidents have increased to an unacceptable level for good will alone. Role will default to the on call Executive Director and Senior Manager. A dedicated SMOC training programme has been developed and delivered in the last 3 years to help address knowledge gaps. However, there is uncertainty if staff will be released this year. Requestes to shorten the course and remove content will leave gaps in knoledge and lack of compliance with minimum occupational stanadards. Training is not mandated Effect - Specialist Advice and support to commanders will not be available for an incident which may impact on patient and responder safety	Major	Almost Certain	20	Historically this provision has been provided on a "good will" free of charge basis, and has not attracted the same financial reconpense afforded to other on call managers. The frequency of calls for advice, and both "stand by" and "Live" incidents have increased to an unacceptable level for good will alone.	Major	Almost Certain	20	On call capability developed A dedicated SMOC training programme has been developed and delivered in the last 3 years to help address knowledge gaps. However, there is uncertainty if staff will be released this year.	Minor	Likely	6	Aug-25	Team Meeting Directorate Meeting	
	EPRR/2025-2611	06/02/2025	The revised deficit for 2025/26 is £56.2m. There are numerous financial targets - breakeven (statutory duty) - £9.1m (WG Target Control Total) - £27.7m (24/25 outturn) The UHB is very unlikely to meet WG set financial targets.	Major	Almost Certain	20	EPRR team will exercise maximum flexibility and provide as much inhouse training as possible at individual staff base.WG / LRF / Multi agency training opportunities which involve travel will be declined until Executive direction permits expenditure.	Major	Almost Certain	20	EPRR team will exercise maximum flexibility and provide as much inhouse training as possible at individual staff base.WG / LRF / Multi agency training opportunities which involve travel will be declined until Executive direction permits expenditure.	Minor	Unlikely	4	Aug-25	Team Meeting Directorate Meeting	
Finance	Fin01/25	Apr-25	Failure to manage recurrent operational pressures and deliver recurrent Cost Improvement Programme which will impact: - Underlying Deficit - Future financial plans - Ability to produce 3 year balanced and approved IMTP	4	5	20	Governance reporting and monitoring arrangements through operational teams, Finance Committee and Board	4	5	20	Development of plan to address the deficit in line with WG expectations in 2025/26 and continue to plan to break even in FY27 and FY28.	5	3	15	Sep-25	Finance & Performance Committee	
	Fin04/25	Apr-25	Remain within Cash limit	4	5	20	Governance reporting and monitoring arrangements through operational teams, Finance Committee and Board CIP tracker in place with a weekly monitoring progress across the organisation	4	5	20		5	3	15	Sep-25	Finance & Performance Committee	
	Fin06/25	Apr-25	Implementation of NHS Wales Job Descriptions for Nursing, Maternity and Theatre Health Care Support Workers Band 2/3 (25/26 estimate c. £5.8m)	5	4	20	The UHB will require cash support from WG for the 25/26 planned deficit of £56.2m along with likely movements in working capital from the 2024/25 balance sheet. In addition outstanding allocations from previous financial years to be confirmed by WG in 2025-26 may bring forward the point of the year when cash controls will require consideration. Cash controls will include the careful management of creditor payment feeds and potential compromise the achievement of the UHB's payment performance targets.	5	4	20	Enhanced scrutiny on cash management ensuring invoices are raised and paid on-time and outstanding debts are chased in a timely manner.	5	2	10	Sep-25	Finance & Performance Committee	

CORPORATE RISK REGISTER SEPT 2025

Clinical Board/ Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
	Fin07/25	Jul-25	Welsh Risk Pool - Increased Risks Apportionments (estimate £6.639m)	5	4	20	Bi-weekly progress monitoring through 'HB Band 2/3 Planning and Implementation Group'	5	4	20	Continued dialogue with Welsh Government and Finance, planning and delivery directorate	5	2	10	Sep-25	Finance & Performance Committee	
	Fin08/25	Jul-25	Welsh Risk Pool - Increased Risks Apportionments (estimate£6.639m)	5	4	20	NWSSP recalibration of in year liabilities over and above plan	5	4	20	Continued dialogue with Welsh Government and Finance, planning and delivery directorate	5	2	10	Sep-25	Finance & Performance Committee	

CORPORATE RISK REGISTER SEPT 2025

Clinical Board/ Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
Medicine	6	08/02/2023	**Context**; Workforce and Capacity constraints across Gastroenterology & Endoscopy are compromising the ability to deliver a robust Gastroenterology service to meet competing demands of the speciality and service i.e. emergency/acute gastroenterology; Endoscopy activity to meet cancer diagnostic/therapeutics/surveillance as well as planned care within speciality components of gastroenterology including services with single handed operators and single points of failure. **Risk;** Delayed diagnosis and treatments of cancer and benign diseases; risk of not fulfilling commissioned activity and income generation; inability to fulfill training needs for trainees in line with HEIW junior doctor training; **Impact**; patient risk of harm due to long waits; poor patient experience; patient concerns; staff burnout; reputational risk; potential to lose trainee posts further impacting on workforce; potential to lose commissioned services	5	5	25	Locum cover for the Medical Workforce gaps and progressing active recruitment Overseas Nurse recruitment and reactive recruitment efforts for Registered Nurses Work with NEP on recruitment strategy #BeVital Weekend insourcing to increase capacity Mobile Endoscopy Unit enabled an increase in activity equivalent to 4 rooms Business Case and Endoscopy expansion Implementation of FIT stool testing as part of patient risk stratification/management	5	5	25	7.02.23 - HR to support the Agenda for Change process to adopt the all Wales Clinical Endoscopist JD to be able to assimilate staff across Wales.	5	2	10	01/07/2025	QSE	
			Context: Intestinal failure/HPN (Home Parenteral Nutrition) is a WHSSC funded south/mid Wales service for patients unable to maintain their nutrition through alternative routes. There is a single Consultant providing clinical leadership but with no succession plan. Due to advances in surgical techniques and critical care there are increased numbers of patients requiring HPN which is commonly needed longer term (increase in patients numbers form 80 in 2015 to 130 in 2019). The funding model has been based upon an inpatient bed day model which does not capture all service components. The service has no current capacity with delays in inpatient transfer and outpatient assessment. There was widespread patient concern & media reporting when there was previous impact on the HPN nutrition chain. An SBAR and case has been submitted to WHSSC **Risk**: Delays in offering nutrition to patients in whom there is no alternative with complications including death & increased length of hospitalisation for shorter term bridging treatments. There is also currently a single consultant with an HPN interest creating significant service vulnerability and gaps in patient care during any times of leave. This is against national nutritional society recommendations **Impact**: Potential harm including death; multiple concerns and media coverage; not meeting national guidelines	5	4	20	**Position** regularly reviewed by nutrition service (crosses CB's) and constraints appropriately escalated **Previous** business case and SBAR to WHSSC for additional service support including consultant post	5	4	20	Medical Workforce challanges with current Lead Consultant standing down by June. Collaborative working with CD&T. Interim short term plan to manage service but no sustainable resolution.	5	2	10	01/07/2025	QSE	
		12/04/2024	**Context:** Current staffing resource in Memory Team cannot meet the demand on the service. **Risk:** Not meeting Welsh Government targets which can have serious consequences. The Memory Team are under significant pressure which is impacting the quality and timeliness of services provided. **Impact:** Increased Wait times (currently 20 weeks). . Delayed diagnositc support. Staff retention risks, Reputational damage.	5	5	25	*Service Manager monitoring waitind list *Support from Directorate * WLIS conducted as and when funding available	5	4	20	SBAR being drafted to outline increase in establishment needed to meet demand	2	2	4	Jul-25		
		21/08/2024	**Context;** Specialties within Integrated Medicine will be breaching 52 weeks in their outpatient waiting list cycle from September/October 2024. This is due to capacity constraints with single handed operators in and increased demand for service. Specialirty areas are *Endocrine - nurse led clinic: *Respiratory – COPD service * Respiratory – ILD service **Risk;** Delayed diagnosis and treatments **Impact;** patient risk of harm due to long waits; poor patient experience; patient concerns; staff burnout; reputational risk; potential to lose trainee posts further impacting on workforce; potential to lose commissioned services	4	5	20	Specialties within Integrated Medicine will be breaching 52 weeks in their outpatient waiting list cycle from September/October 2024. Endocrine - nurse led clinic: • Clinic is run by one member of staff on alt weeks. Due to the level of detail given to patient there are only 4 news seen per clinic. • Were increasing clinic capacity to 3 per month but due to nursing vacancy within team this has stopped • Consultants unable to support due to 2 x vacancies within team Respiratory – COPD service: • Clinic is run by one Consultant • Increase in demand post covid and due to being delivered by one member of staff unable to increase further. • Sought to obtain dedicated SpR/CRF but not possible due to staffing levels Respiratory – ILD service: • Ongoing increase in demand. • Capacity issues earlier in the year due to consultant absence • Clinical decision made to see urgent patients only due to length of waiting time • Overall capacity issue with follow up due to increases in patient numbers and change in treatment options.Sending validation letters to long waiting patients increasing capacity when possible	4	5	20	April 2025 - robust action required to address the clinical risk associated with long waits/ delayed treatment and FU across several services across IM. Urgent action required. Will update in May 2025	3	3	6	Jul-25		
		21/11/2024	**Context;** Lack of capacity in the Intestitial Lung Disease Service (ILD). This is affecting new and follow up patients. ILD is a life limiting condition and therefore patients need to be seen routinely. The ILD team do not have enough capacity to adequately deliver their service, as such they are currently only seeing urgent new cases and the longest wait time for routine new patients is at 58 weeks. The lack of capacity is impacting the front door as patients are presenting to MSDEC and also being seen as inpatients. In addition there are 70 patients waiting for initiation of nintedanib treatment and as a result we are not compliant with NICE guidelines. **Risk;** Delayed diagnosis and treatments **Impact;** patient risk of harm due to long waits; poor patient experience; patient concerns; staff burnout; reputational risk; potential to lose trainee posts further impacting on workforce; potential to lose commissioned services	5	5	25	1. Efficiencies made in service and patient now being seen by CNS and respiratory physiologist as well as Consultants. 2. Business case being drafted to increase staff and capacity Further controls in place from April 2025: 1. Consultants to clinically validate the list of patients with FU appointments beyond their clinical target – confirm which patients need appointments brought forward 2. Additional clinical sessions to accommodate patients that need urgent FU 3. Increase NOP and FU capacity across the ILD service by introducing a clinical fellow post for 12 months initially from August 2025 4. Escalate the clinical risk to the MCB and ensure the risk is accurately described on the directorate and clinical board risk register. 5. Consider options to increase ILD consultant activity by backfilling acute respiratory work 6. Review the Clinical Nurse Specialist duties to ensure we are maximising patient activity and whether there is scope to increase 7. Prepare bid for RTT funding from Q2 to address long wait NOP	5	4	20		3	3	6	Jul-25		
		09/08/2024	Endoscopy - EMR/ESD/EUS/ERCP Event - There is a risk that some complex procedures (i.e. Endoscopic mucosal resection (EMR), submucosal dissection (ESD) of colorectal and upper GI tract lesions, upper and lower GI Endoscopic ultrasound (EUS), Endoscopic Retrograde Cholangiopancreatography (ERCP)) may be delayed beyond desired timeframes. Cause - This is caused by limited capacity due to there only being a single handed operator with the skill required to undertake these specialised endoscopy procedures. Effect - Which could lead to harm including death; if patients do not receive therapeutic procedures in a timely manner they are at risk of deteriorating further and can then require more invasive interventions or progress to non-curative status.	5	5	25	Additional sessions offered to clinicians to increase capacity for complex endoscopy Formal arrangement in place with ABHB for EMR. Prioritisation of patients by clinicians based on clinical urgency.	5	4	20		5	2	10	Juk 25	Clinical Board Q&S Meeting Clinical Safety Group Directorate Q&S meeting Directorate Safety & Quality Session (Audit)	

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Mental Health			The issue of St Barruc being an isolated unit is not new, but the acuity of patients being admitted to the ward and needing acute care has risen considerably over the last 5 years. The purpose built ward was designed with 3 units which aimed to care for patient through different stages of their illness. However, the layout and isolation of the ward together with increased acuity now requires an increase in staffing levels and skills and more physical health support, as there is a constant risk of another serious incident occurring. Incident in August 24 relating to doors only opening one way; risk of patient barricading themselves in, and no viewing opportunites, with window restrictors and window film. We therefore feel the ward is no longer fit for purpose as an acute mental health inpatient ward	4	5	20	GP attend twice a week. Increase Senior Nurse support to twice a week. Including physical health nurse. News 2 implemented to identify deteriorating patient. Clear procedure to access 999. Physical Heath Training Sessions provided to staff. Training to be provided – bladder scanner/ECG. All staff to be trained in ILS. All staff to be trained in SIMA. Consider moving physically/ acutely unwell patients up to UHL However none of this mitigates the risk of the location and risk associated with this.	4	5	20	(1) Director of Nursing to email clinical board to ascertain whether the Directorate need to do anything in preparation for ward move (2) Staff consolation (3) Public consolation Visits by Executive team (Completed) (4) Planning have visited St Barrucs (Completed)	3	3	9	Jan-26	Future Hospitals	
PCIC	PC037	16/07/2025	Tripartite negotiations took place from Sept 2023 to Oct 2024 between Welsh Government, NHS, and the Welsh General Dental Practice Committee to design and develop a new GDS contract. The goals of the contract are: Improve population health, oral health, and well-being through a greater focus on prevention. Improve access, experience, and quality of dental care for individuals and families. Enrich the well-being, capability, and engagement of the dental workforce; and Increase the value achieved from funding of dental services and programmes through improvement, innovation, use of best practice, and eliminating waste. The proposal offers flexibility for health boards to adapt requirements locally, but trust in such flexibility is low due to past inconsistencies. If providers feel overwhelmed or fear financial penalties (claw back), some may leave the NHS entirely. This would be particularly damaging, as it would lead to reduced access and push more patients towards private care. As low-need patients are encouraged or forced to go private, this could further entrench inequalities in access to care. The changes also risk demoralising the dental workforce. General Dental Practitioners may find themselves treating a higher volume of unfamiliar moderate-need patients, without the rewarding continuity of care that comes from long-term patient relationships. Conversations with displaced patients, especially those moved to DAP or alternative pathways, will be difficult. In addition, while the proposal attempts to simplify pay structures, the self-employed nature of much of the dental workforce makes a shift to salaried roles less appealing. The role of the Community Dental Service (CDS) in the proposal raises alarms. CDS is meant to serve the most vulnerable populations, yet the plan suggests it will take on treatmetn for the highest-need GDS patients. This would stretch an already overloaded system and divert resources from its core mission. Any such change would require not just funding, but also a workforce solution, something not adequately addressed in the proposal (though WG have since described a plan to bring dentists from India to start this service). Even if high-need patients are stabilised in GDS before transfer, delays and lack of continuity will result in duplicated efforts and poorer outcomes. Cause / Source / Event The proposed contract reform to General Dental Services (GDS) is expected to have significant, wide-ranging impacts, both operational and clinical, with many concerns raised by dental service providers around access, patient care, and workforce morale. There is lack of clarity around how many patients practices will be expected to treat. This makes it difficult to compare current activity with future expectations. The proposal assumes a level playing field across practices, but there is variation in patient demographics and existing workload. Practices in areas of higher deprivation, which typically treat more high-risk patients, are unlikely to benefit from the efficiencies offered by transferring low-risk patients onto the Dental Access Portal (DAP). As a result, they will face increased pressure, potentially compromising recall intervals and reducing capacity for new patients. In contrast, practices in more affluent areas may find it easier to shift low-risk patients onto DAP, freeing up appointments and improving access. Further deterioration in the morale of the GDS workforce. Return of NHS dental contracts. NHS dental activity delayed / lost due to the time constraints within the procurement tender processes. Lack of interest from the dental community in any subsequent procurement tender process . Loss of NHS dental provision and activity. Potential for CDS to be overwhelmed. Strategic objectives 1, 2, 4, 5, 7, 8	5	4	20	*1. The UHB has submitted a full response to WG regarding the new dental contract proposal outlining the potential risks relating to the proposed changes. 2. The HB contributed to responses from other stakeholders. 3. The HB continues to communicate frequently with the LDC to understand their concerns. 4. The Community Directors for GDS continue to communicate with the Dental Directors Group to unpick ambiguities and clarify unclear aspects of the proposal. 5. When the final version of the contract is confirmed, the HB will need to consider how best to mitigate the various consequences described, not least the likely loss of NHS provision, and the potential for CDS to be overwhelmed.	5	4	20	None	5	4	20	Sep-25		
	CAV 11	45474	Worker Status of GPs Risk: There is a risk that some GPs may challenge their worker status with the UHB Source of uncertainty/cause/event: Recent cases in NHS Wales where GPs have successfully challenged their right to worker status, working for an OOH provider in another UHB	4	5	20	Salaried GP roles offered to all GP's. Updated consultancy agreeement shared with all GP's. Working closely with Legal and Risk	4	5	20	Attend/await updates from ongoing weekly meetings with WOD & DOF	5	2	10	Jun-25		
	MM00S NB duplicate number	25.08.15	Prescribing Budget Risk: risk of overspend in the prescribing budget Source of uncertainty/cause/event Volatility of drug tariff, category M prices, drug shortages and NCSO consessionary pricing, growth in volume, increased use of expensive medicines in primary care, Savings are increasingly hard to find that have no detriment to patients or require a GP appointment, and appetite to support switches is decreasing Consequence/impact Spend is more than forecast and mitigating solutions are limited				Medicines Management team deliver efficiencies in primary care drug budget, identify and reduce wasteful use of medicines, reduce variation, work with secondary care to manage the introduction of new drugs	4	5	20	Targeted improvement work and engagement Improvement in analytics to inform and prioritise workplan Update July 2025: Risk remains high, with substantial overspend despite best efforts. Escalation demonstrating the wider-UHB influences on the budget outside of the Clinical Board. Review of Corporate Medicines Management Group underway to improve governance around decision making that may influrece the PCIC Prescribing Budget	4	2	8	Sep-25	Finance Committee	
	HMP - 18		There is a risk that the Healthcare Dept at HMP Cardiff is unable to meet the needs of patients due to staffing levels in the nursing team. This affects the administration of medication, the assessment of new arrivals and the ongoing triage and care of patients.	4	5	20	1. Regular staff meetings. 2. SMT undertaking OD work to cascade. 3. Support for those staff who feel they're subject to concerns/issues raised. 4. Management provided to staff when concerns raised. 5. Improved HR support	4	5	20	1. OD Work with HMP. 2. Regular SMT presence in HMP. 3. Further promotion of expected values and behaviours of staff	4	2	8	Jun-25	Quality Safety and Experience Committee	
	20	01/01/2010	**Haematology and Immunology - Clinical Environment** Lack of isolation cubicles and appropriate filtration on Ward B4H. Insufficient number of toilets/washrooms. Increased risk of cross infection, existing facilities difficult to access. Individual toilets isolated on a named basis for high risk cases. Seperate commodes for c.diff and BMT patients. Footprint for BMT patients inadequate. En-suite facilities required.	5	5	25	Policies, protocols, and guidelines available. Cleaning schedules. Installation of air pressure gauges outside BMT cubicles to measure positive air pressures. Patients admitted to ward A4 North (amber) for triage prior to admission to B4 (green).	5	5	25	Escalated to Clinical Board, estates, Capital Planning Team and WHSSC. C.O.S has been drafted and work with capital and estates is ongoing to develop plans for new area.	1	1	1	01/04/2024		Patient Safety Staff Wellbeing Workforce Critical Care
	21	17/02/2020	**Haematology, Immunology and Metabolic Medicine - TYA Oncology Services** TYA cancer patients may elect to have their treatment on the designated TYA cancer unit hosted in UHW. Chemotherapy plans are determined by the site specific MDT/Consultant and facilitated by the TYA cancer Team on the unit. Chemotherapy is currently prescribed by the Consultant or TYA Staff Grade. Chemotherapy may be prescribed in 4 different ways. As a result, there are risks around: -Transcribing of chemotherapy - Lack of oversight of chemotherapy being prescribed by oncology clinician for their TYA patients -Variation in practices between UHW and VCC Overreliance on individuals to make the TYA oncology cancer care delivery work, including patients and families to provide history	5	4	20	Email correspondence from VCC Clinician confirming treatment plans. Expertise in pharmacy and nursing teams involved in TYA cancer care delivery.	5	4	20	Access to VCC chemocare on TCTU. Treatment plan proforma to be usitlsed by all TYA cancer patients. TYA team to access and use Canisc. Systems ready, staff being trained (completion end of December) working through protocol. Senior nurse working with Velindre on solution.	5	1	5	01/04/2024	QSE	Patient Safety Critical Care

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Specialist Services	23	########	**Haematology and Immunology - Office Accommodation** Insufficient and/or inappropriate office accommodation is available for clinical, managerial and administrative staff across the directorate. Ongoing serious maintenance/estates and Health and Safety issues in the BMT offices in Jubilee Gardens which presents a significant risk, including poor ventilation and water leaks in the area causing damage to UHB property, disruption to services and a serious Health & Safety risk to staff based in that area.	4	5	20	Issues escalated to Clinical Board and Medical Director's Office as a Health & Safety issue for staff. Health & Safety team and Estates Management aware. Estates team are monitoring the situation.	5	4	20	Alternate suitable office accommodation needs to be identified to allow clinical and managerial staff to continue to work in a more appropriate environment.	1	1	1	01/04/2024	Future Hospitals	Capital Assets Patient Safety Critical Care
	31	27/08/2021	**Neurosciences** Prolonged waits for epilepsy new case and follow up outpatient due to consultant vac / sickness	4	5	20	Maintaining current epilepsy clinics, clinical board aware of patient risk as 'First Fir' clinic stood down on Fridays.	5	5	25	Approval from clinical board to appointment band 8a prescribing pharmacy role using clinical fellow funding - advert going forward with CD&T CB.	4	1	4	01/05/2025		Patient Safety Capital Assets
	32	27/08/2021	**CARDIOTHORACIC** Deaths on Cardiac Surgery waiting list Provision of Cardiac Surgery - including ability to meet 36 week RTT, ability to treat urgent patients, impact of staff shortages (theatre and CITU staff), impact of lack of access to inpatient beds leading to increased mortality and morbidity of patients on the WL	5	4	20	Daily validation of cardiac surgery waiting lists by the directorate management team. Weekly monitoring of booking and scheduling, utilisation and productivity. Weekly cardiac surgery operational meeting to discuss cancellations, late starts, overruns and staffing constraints. Standardised communication processes for patients on the waiting list for cardiac surgery.	5	4	20	Recruitment of theatre personnel. Daily flow monitoring to ensure timely transfer between CITU and Ward C5	5	4	20	Monthly in Directorate DMT/Q&S Meeting	Weekly RTT meeting, Directorate performance review, CB& Directorate Q&S meetings, WHSSC performance meetings	Patient Safety Capital Assets
	40	Jan-22	**CARDIOTHORACIC** Interventional/structural cardiology capacity is unable to manage referral demand leading to increasing waiting times and inevitable clinical risk.	5	4	20	Daily validation of cardiology waiting lists. Regular feedback to the consultant body highlighting long waits. Backfilling of vacant cath lab lists stoppped due to financial constraints.	5	4	20	Discussions ongoing in terms of the development of a 4th cardiac catheter lab. Work being undertaken with University to right size cardiology commenced April 24.Right sizing paper completed.	5	2	10	Monthly in Directorate DMT/Q&S Meeting	DMT, Diagnostic Delivery Group, Clinical Board performance reviews	Patient Safety Urgent & Emergency Care
	42	Sep-19	**CARDIOTHORACIC** Ability to recruit and maintain specialist staff groups in particular Cardiac Physiology workforce. Significant risk to the regional Primary PCI service.	5	4	20	Robust monitoring of vacancies. Early reporting and proactive recruitment. Undertaken staff pulse surveys to understand current constraints and implement action plan to address concerns. Established successful Band 5 Cardiothoracic rotation programme to increase recruitment. Introduced fast training for echocardiography. The appointment of STP roles within cardiac physiology. Primary PCI service discussed through the cardiac network group. Attending wider recruitment events. Utilising off ward nurses to mitigate risk and support senior presence in ward areas	5	4	20	Business cases submitted to WHSCC for physiology to support TAVI and complex ablation. RTT planning to include the recruitment of 3 Band 7 physiologist.	5	3	15	Monthly in Directorate DMT/Q&S Meeting	Specialist Clinical Board & Directorate team	Patient Safety
	43	Jul-22	**CARDIOTHORACIC** The relocation of C3N cardiology provision to support return of cardiothoracic services to UHW and relocation of critical care provision.	5	4	20	Secured discharge lounge to relocate T&R service from B1 to open 4 additional inpatient beds on B1. Retaining 6 beds on C3N to maintain CCU stepdown to minimise clinical risk.	5	4	20	Project team established	5	2	10	01/10/2025	Capital Estates Cardiothoracic Project Team	Patient Safety Urgent & Emergency Care
	34	25/03/2019	**Neurosciences** Failure to implement the revised MHRA guidance related to sodium valproate. Patients unborn child will come to harm as a result of failure to adhere to the pregnancy prevention programme.	5	4	20	Sodium valporate coordinator in post. Central database being updated in line with current demand.	5	4	20	Initially targetting the high risk patients that have been non compliant with PPE. Working with Health Board and GPs to ensure safe transfer of service.	5	1	5	01/05/2025		Workforce
	55	31/01/2024	**Haematology and Immunology** Single handed consultant (Gastro) NET service. Sigle handed consultant delivered service for cominssioned South Wales Neuroendocrine Cancer Service since 2017, unsuccessful recruitment despite resource from WHSCC. High risj of servoce collapse with in creasing patient numbers, no cover for leave/sickness etc.	5	5	25	Executive oversight (COO) with transition into new clinical board.	4	5	20	Restrictions on service to be explored if no other solutions not identified. Esplore all solutions for second consultant (meeting with consultants TBA). Dr Haboubi to provide dates for monthly clinics for 2024. plan to optimise non-medical support of service - admin roles, new cancer service roles, roles of existig CNSs. Gastro registrar to rpovide limited input into service for education and troubleshooting. Clinical fellow to be appointed.	4	3	12	May-24	QSPE	Patient Safety
	56	05/09/2019	**Neuroscience** Inability to meet 52-week and 36-week RTT targets for Cardiff and CTM Neurology patients. Leads to poor experience/outcome for patients and poor reputation.	4	5	20	Daily management of waiting lists by SMs, demand-capacity work undertaken and extra clinics arranged where necessary.	4	5	20	Validation of waiting lists. Cardiff capacity currently being utilised to help the CTM waiting list position - detrimental impact on Cardiff waiting times. Weekly meetings with CTM management. Escalated with exec and clinical board, discussions ongoing to reveiw medical model.				01/05/2025		Patient Safety
	61	Nov-23	**Cardiothoracic** The relocation of C3N cardiology provision to support return of cardiothoracic services to UHW and relocation of critical care provision.	5	4	20	Secured discharge lounge to relocate T&R service from B1 to open 4 additional inpatient beds on B1. Retaining 6 beds on C3N to maintain CCU stepdown to minimise clinical risk.	5	4	20	Project team established	5	2	10	Jun-24	Capital estates, Cardiothoracic Project Team	Workforce
	79	03/05/2022	**Major Trauma** **There is a risk to patient safety and patient flow for those patients with issolated nonoperative brain injury due to lack of agreed speciality ownership.**	4	5	20	Impacted MTC TBI patients discussed daily in MTC MDT and a bespoke solution is souhgt on a case by case basis.	4	5	20	MTC DMT to chase response by w/e 6th May 2022. Meeting with MTS and Neurosurgery 07/22 and then further meeting facilitated by Medical Director 08/22. 01/06/23 ED have submitted BC for X6 additional trolley spaces for CDU.	2	2	4	Monthly		Patient Safety
	86	06/12/2022	**Major Trauma** There is a risk around paediatric nurisng capacity within ED which may impact the delivery of care given 24/7.	4	3	12	Staff work on a rotatinal basis.	4	5	20	ED to develop business case and submit for consideration to MCB. 09/23 repeated escalation by ED via governance processes given clinical risk. Risk reviewed and increased.	2	1	2	Monthly		Workforce Patient Safety
	89	06/02/2024	**Haematology and Immunology** Vacancy for nurse practitioner and insuffuficient medical staff support has resulted in an increased reliance on the nursing team who are already at capacity. There is a need to ideally provide 24/7 NP cover to ensure greater governance and oversight of patient care, delivery of treatments and to support the medical workforce. This would support the sustainable dvelopment of nursing staff, career progression to the ANP role required for the new Haem/BMT facility. Due to the high number of inexperienced staff and high acuity on the ward there is a significant risk to patient care. In particular timmely care, inadequate knowledge/experience impacting on decision making, lack of continuity of care and poor oversight of medical support. No ward sister and inexperienced deputies also increase the risk on B4H.	5	4	20	One post has been advertised, SBAR submitted to CB for consideration however, CB have requested further details inrealtion to roles, responsibilities and impact. Currently there is no funding stream for the additional posts which are required. Finance have agreed to reconfigure funds from existing establishment to create additional band 7 NP post. Tis will provide a limited NP servoce which will significantly reduce the risk for nursing staff and patient care. This would be a bridging support until the new workforce model has been agreed.	4	4	20	To explore models of funding. Lead Nurse to undertake wider benchmarking nationally and review workforce modelling to support the NP roles. Ned to secure CVSP approval to appoint second NP post.	2	3	6	Apr-24	QSPE	
	92	Jun-24	**CARDIOTHORACIC** Ward B1 Central monitoring requiring upgrade, currently capacity to monitor 32 beds. Inadequate level of monitoring to provide required care for an acute Cardiology Ward up to 38 beds. Current monitoring out of support since Dec 2022.	5	4	20	Submission of Capitol bid to increase capacity to monitor up to 38 beds and ensure adequate servicng and maintencance of the mornitring is in place to ensure sustanability of service	5	4	20	Bid to be submitted by clinical engineering following completion	5	1	5			
	93	Aug-24	**CARDIOTHORACIC** Deaths on TAVI waiting list Provision of TAVI Service - including ability to meet 36 week RTT, ability to treat urgent patients, lack of access to inpatient beds leading to increased mortality and morbidity of patients on the WL	5	4	20	Daily validation of TAVI waiting lists by the TAVI Team. Weekly monitoring of booking and scheduling, utilisation and productivity. Standardised communication processes for patients on the waiting list for TAVI. Regular feedback to the consultant body highlighting long waits.	5	4	20	Discussions ongoing in terms of the development of a 4th cardiac catheter lab. Work being undertaken with University to right size cardiology commenced April 24. Appointment of vacant Consultant Interventional/Structural Cardiologist - awaiting start date. recruitment of a locum consultant interventional cardiologist to support acute/elective work whilst we recruit for substantive post. Implementation of a ring-fenced mixed gender bay to mitigate risk of cancelling elective TAVI admissions.	5	3	15	Monthly	Weekly RTT meeting, Directorate performance review, CB& Directorate Q&S meetings, JCC performance meetings	
	99	12/07/2022	**Critical Care** Lack of physical Emergency Critical Care beds at UHW to admit current and predicted Critical Care Demand to 2030. Delays in Emergency admission to Critical Care result in avoidable deaths and impaired functional outcomes. Emergency Critical Care has 35 Level 3 commissioned beds. Due to its specialist nature, the majority of Critical Care work undertaken at Cardiff and Vale cannot be undertaken anywhere else in Wales.	5	5	25	Cuurently the directorate are occupying the use of a surge ICU area (C 3 Link) to provide 10 additional physical beds. Capital Planning are in the design process for refurbishment and expansion of Critical Care.	5	4	20	Undertake Design work to produce an outline cost for refurbishment and expansion of Critical Care beds, overseen by Program Board. Seek funding for expansion and refurbishment. Clarify commissioning arrangements.	4	2	8		Future Hospitals	
	100	12/07/2022	**Critical Care** Lack of dedicated infrastructure for a Long Term Ventilation Unit at C&V. The lack of a dedicated unit causes great uncertainty about the future viability of the service and this severely affects recruitment. In turn this requires acute Critical Care nurses to care for LTV patients, further reducing Critical Care capacity which is also noted as a Critical risk. The service is at risk of closing. This would have a significant effect of Welsh Critical Care capacity and Healthboard reputation.	4	5	20	Approach made to Critical Care Network to seek an alternate provider of LTV services – no other provider	4	5	20	To build a bespoke 10 bedded LTV facility	1	1	1		Strategy&Delivery	
	102	12/07/2022	**Critical Care** Lack of patient isolation facilities in UHW Critical Care Unit - Due to lack of isolation facilities UHW Critical Care has had to operate a cohorted COVID-19 ward (A3S) for over 2 years. If for example there are 2 patients with COVID-19, this takes a full 9 Critical Care beds out of use for other patients, meaning there has been need to operate in surge Critical Care areas ever since the beginning of the Pandemic. This is very inefficient outside of a major surge of COVID. The same approach would be expected to be employed in an Influenza Pandemic. In 2020, Cardiff & Vale opened a High Consequence Infectious Disease (HCID) Unit at UHW. This is intended to be utilised by non-Critically Ill patients with airborn pathogens such as MERS and TB. Currently there is only 1 room at UHW Critical Care Unit available to treat patients who become Critically Ill in the HCID. Us of this location may potentially mean the 8 beds distal to it are unusable for the duration.	4	5	20	Staff prioritise patient with highest need to isolation. Trial of temp isolation cubicles were found to be unsuitable in Critical Care.	4	5	20	Firm plan for the renovation specifically targeting issues mentioned.	4	2	8		QSE	
		12/07/2022	**Critical Care** Obsolete Pendants systems providing medical gases to patients on the Critical Care Unit - Failure of a hose or connector, in the next 10 years, without appropriate spares could result (in the best case scenario) loss of a single bed space, or (in worst case scenario) loss of 9 bedspaces for an extended period whilst emergency refurbishment occurs. This could be a period of several months as lead times for new Pendants are currently long. This would have a major effect on Tertiary Critical Care Services in South Wales.	5	5	25	No controls	4	5	20	Firm plan for the renovation specifically targeting issues mentioned.	1	1	1		QSE	

CORPORATE RISK REGISTER SEPT 2025

Clinical Board/ Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
	105	12/07/2022	**Critical Care** Sub-standard Heating, Ventilation and Air Circulation system in the Critical Care Unit - Lack of assurance re: protection of staff and patients from airborn pathogens. Lack of assurance re: ability to host key services such as Haematology and HCID. Patient discomfort. Staff discomfort resulting in impaired staff retention. Risk of HCAI due to use of mobile air conditioners Risk of impaired brain outcomes due to difficulty treating pyrexias. Risk of delirium due to over-reliance on blinds to reduce temperature. Risk of ineffectual existing HVAC due to having windows open and risk of air pollution.	5	5	25	Use of mobile air conditioners (risk of increasing HCAI). Use of patient skin cooling devices (cost). Use of blinds (risk of delirium). Opening windows (reduces effect of existing system and causes pollution) and staff comfort measures on hot days (cool drinks, cold lollies, wearing scrubs)	4	5	20	Firm plan for the renovation specifically targeting issues mentioned.	4	2	8		QSE	
	106	12/07/2022	**Critical Care** Lack of appropriate Level 2 and 3 facilities to admit Critically ill patients escalating from UHW High Consequence Infectious Disease Unit - in 2020 Cardiff and Vale Healthboard built a 10 bed High Consequence infectious Disease Unit at the UHW site. This facility is for airborn High Consequence infectious diseases (eg MERS) as opposed to contact infectious diseases (eg Ebola). Upon opening an assessment of the suitability of the HCID to provide level 2 and 3 Critical Care was made. The conclusion was that although the facility may (like other areas of UHW) be suitable for a Critical Care team to reach out and stabilise and intubate a patient there, it was not suitable for ongoing Critical Care. Patients would need to be transferred to a suitable Critical Care Unit for ongoing care.	4	5	20	One isolation cubicle capable of receiving these patients with operational disruption due to location	4	5	20	Firm plan for the renovation specifically targeting issues mentioned.	4	2	8		QSE	
	110	Mar-25	**CARDIOTHORACIC** Temporary loss of 4 cubicles on C5 in order to support the wider UHB priorities to expand renal capacity following IP&C issues.	4	5	20	Regular review of bed capacity versus activity for both cardiothoracic surgery patients and reduction of cardiology footprint until the relocation of C1 with high risk of IP&C issues currently resulting in closed beds.	5	4	20	Directorate bed management rota to work closely with bed managers to maximise all capacity and early escalation of constraints. Weekly scheduling meetings with theatres.	5	4	20	Jul-25	DMT, clinical board, exec team	
	111	Mar-25	**CARDIOTHORACIC** Extremely long waiting lists for a new cardiology outpatient appointment due to demand and capacity constraints.	5	4	20	Text validation exercise to take place by central validation team to patients waiting over 52 weeks. Increase of urgent versus routine ratio to support seeing more referrals triaged as urgent. WCP triage sessions allocated to new consultant job plans to support enhanced triage of referrals. Demand and capacity work evidences gap in capacity.	5	4	20	Directorate team working closely with medical records to ensure all new patient slots are utilised. Working with central validation team to conduct text validation exercise for all patients waiting over 52 weeks initially.	5	4	20	Monthly	DMT, clinical board, exec team	
	112	Apr-25	**CARDIOTHORACIC** Delays to treatment of lung cancer patients due to loss of theatre lists. Staffing constraints due to recruitment and retention issues and stopping of overtime. Increased demand due to lung cancer screening with further increase in demand expected on further roll out of screening. Impact on benign inpatient waiting list due to lung cancer being prioritised.	5	4	20	Weekly validation of thoracic waiting list by the directorate management team. Weekly monitoring of booking and scheduling, utilisation and productivity. Weekly theatre scheduling meeting to discuss cancellations, late starts, overruns and staffing constraints. Weekly attendance at wider UHB cancer tracking meeting.	5	4	20	Recruitment of theatre personnel.	5	4	20	Monthly	Weekly RTT meeting, directorate performance review, CB and directorate Q&S meetings, JCC performance meetings	
	113	Jul-24	**Critical Care** Inability to save and upload lung ultrasound images to central storage system. Ultrasound accredited physios within critical care are using lung ultrasound as a component of their respiratory assessment. At present there is no ability to centrally save and upload the lung ultrasound images to a central UHB storage system Therefore there is a lack of governance over the interpretation of the findings and how that influences physio interventions. provides challnegs to the training process.	4	5	20	Staff undertaking lung ultrasound FUSIC training and accreditation. Production of lung ultrasound reports at time of scan completion with detailed findings. Having access to UHB physio and medical FUSIC mentor/supervisor. The ultrasound machines have some ability to store a finite number of images.	4	5	20	UHB solution to ultrasound storage for scans completed outside of radiology department. Regular clinical supervision sessions with mentor. Regular peer review of scans. Thorough documentation on reporting forms and ensure they are filed in patient records.	5	4	20		QSE	

Division	Speciality	Risk ID	Risk title	Date raised	Risk event	Risk cause	Risk effect	Reported group (Committee)	Initial rating score	Initial impact rating	Initial likelihood rating	Initial RAG	Initial rationale	Current rating score	Current impact rating	Current likelihood rating	Current RAG	Current rationale	Target rating score	Target impact rating	Target likelihood rating	Target RAG	Target rationale	Response (Status)	Key controls	Assurance on controls	Gaps in controls	Treatment plan	Barriers	Review dates
Capital Estates and Facilities	CEF - Asbestos	CEF - Asbestos/2025-2609	Asbestos Information - Not having sufficient notice on projects to allow R&D surveys to be done in advance of project start	18/08/2025	There is a risk that not having sufficient notice on projects to allow R&D surveys to be done in advance of project start creates a financial / time pressure on projects.	This is often caused by the time available for projects being limited at the outset and this means there is not enough time between decanting of an area and the PC beginning works.	Undertaking R&D surveys late can cause delays when notifiable ACMs are found or can mean LARC and PC are having to work on site together unnecessarily. There is also the increased potential for disturbance of friable asbestos and subsequent asbestos exposure of individuals.	Team Meeting Directorate Meeting Directorate Q&S meeting	15	Catastrophic	Likely	Red	Any risk with the potential to have people exposed to airbourne asbestos fibres is rated as Catastrophic. The likelihood is based on the fact that these delays are frequent and that over the last 3 years there have been several "potential asbestos exposure incidents" recorded where this specific issue was noted as the primary cause.	15	Catastrophic	Likely	Red	Any risk with the potential to have people exposed to airbourne asbestos fibres is rated as Catastrophic. The likelihood is based on the fact that these delays are frequent and that over the last 3 years there have been several "potential asbestos exposure incidents" recorded where this specific issue was noted as the primary cause.	10	Catastrophic	Unlikely	Amber	The aim is to reduce the likelihood score by building in sufficient time in advance of refurbishment works for surveying to be completed and reported.	Tolerate	The AIR process should ensure that relevant asbestos information is provided to the contractor in advance of the project start. Where R&D surveys are required these need sufficient access and time to allow the survey to be undertaken and processed to allow a timely issue. Has document: No Owen Davies 18/08/2025 10:06	1. The AMT are usually involved at the outset of most projects. This provides opportunity to influence the logistics required to provide relevant asbestos information to the PC in advance of work starting. 2. Staff training consistently reinforces the need to provide the PC / contractors with relevant asbestos information. 3. Staff are asked to try and build in time into the projects to allow surveys to be completed in advance of construction works beginning. Has document: No Owen Davies 18/08/2025 10:07	The timescales in some projects are so tight that often the areas are not decanted until a few days before the project is due to start. This means the R&D survey is often not completed or issued when the project starts. This often causes projects to be delayed when asbestos is identified and it creates issues in programming the project. It has also meant asbestos work being planned for the middle of projects when it would be advantageous to do the work in advance of the main project starting. It often means there is insufficient time to undertake a comprehensive removal of ACMs and means items get left in situ. Has document: No Owen Davies 18/08/2025 10:08	Y		
Capital Estates and Facilities	CEF - Asbestos	CEF - Asbestos/2025-2610	Asbestos Information - Provision of asbestos information to long term compliance contractors	18/08/2025	There is a risk that compliance contractors working on our sites with inadequate asbestos information are more likely to be exposed to airbourne asbestos fibres	This is caused by them being more likely to disturb asbestos containing materials if they do not know where they are	Disturbance or damaging of friable asbestos asbestos containing materials has the potential to expose them to airbourne asbestos fibre levels above the control limit (0.10 f/ml) and can have the potential to cause asbestos related diseases	Team Meeting Directorate Q&S meeting	15	Catastrophic	Likely	Red	If they were to be exposed to asbestos as a result of thier works the health impact could be catastrophic. Currently there a significant number of contractors permanently working on site with no asbestos information (either given to them or accessed themselves) so the likelihood of them being exposed is more likely (if not common) than if they did have the rleevant information.	15	Catastrophic	Likely	Red	If they were to be exposed to asbestos as a result of thier works the health impact could be catastrophic. Currently there a significant number of contractors permanently working on site with no asbestos information (either given to them or accessed themselves) so the likelihood of them being exposed is more likely (if not common) than if they did have the rleevant information.	10	Catastrophic	Unlikely	Amber	The aim would be to reduce the likelihood of them being exposed by ensuring that they have access to the relevant asbestos information for the area they are working in.	Tolerate	All compliance contractors have access to the asbestos register MiCAD, have been given a training guide and have been told to check the asbestos register when 1. they access an area for the first time or haven't been in an area for a while (more than 6mths) 2. they need to work in a plant room, service area or estates area 3. they need to work on a ceiling or within a ceiling void 4. they need to work within a riser, floor duct or void 5. they need to undertake intrusive work (interfering with the fabric of the building or other services Has document: No Owen Davies 18/08/2025 10:44	Monthly audits to identify how many times the data base has been accessed by contractors. The audit process has been developed further and can now target individuals in comparison with the number of tasks undertaken or areas accessed. The results of this audit is sent to the Supervising Officers for managing and is also highlighted within the Monthly Asbestos PROP report. Has document: No Owen Davies 18/08/2025 10:44	The range and number of contractors and the extent of their works makes it difficult to monitor them to understand whether they are doing a relevant number of asbestos checks. Has document: No Owen Davies 18/08/2025 10:51	Y		
Capital Estates and Facilities	CEF - Building	CEF - Building/2021-2202	Plant Room Roofs - UHW. Profiled steal sheeting	02/08/2021	Roofs are metal profile on steel girders. On A block plant room there is obvious signs of Corroision with daylight showing clearly on the far right side. Lift rooms roofs leaking causing down time on lifts - Risk / roofs sheets corroding causing collapse of roof - Impact / loose sheets have the potential to fall putting pedestrian and vehicle traffic at risk here is a risk that	Corrosion, possible damage during installation, inability to maintain safely.	Lift rooms roofs leaking causing down time on lifts - Risk / roofs sheets corroding causing collapse of roof - Impact / loose sheets have the potential to fall putting pedestrian and vehicle traffic at risk here is a risk thathich w/could lead to an impact/effect on	Team Meeting Board	25	Catastrophic	Almost Certain	Red	Plant room roofs at UHW are showing signs of degragation and failure. Roofs are metal profile on steel girders. On A block plant room there is obvious signs of Corroision with daylight showing clearly on the far right side. Lift rooms roofs leaking causing down time on lifts - Risk / roofs sheets corroding causing collapse of roof - Impact / loose sheets have the potential to fall putting pedestrian and vehicle traffic at risk	25	Catastrophic	Almost Certain	Red	Plant room roofs at UHW are showing signs of degragation and failure. Roofs are metal profile on steel girders. On A block plant room there is obvious signs of Corroision with daylight showing clearly on the far right side. Lift rooms roofs leaking causing down time on lifts - Risk / roofs sheets corroding causing collapse of roof - Impact / loose sheets have the potential to fall putting pedestrian and vehicle traffic at risk	10	Catastrophic	Unlikely	Amber	Put a plan in place to formally monitor roof in A block and carry out full structural survey of all roofs including lift plant room roofs, replace roofs.	Tolerate	Early signs of corrosion, roof is reasonably stable at present roof is to be continually monitored to check for further signs of structural loss Has document: No Adrian Griffin 13/08/2025 15:18	Roof is subject to ongoing monitoring. Has document: No Adrian Griffin 13/08/2025 15:19	No plan at present to address the issues. No plan at present to address the issues. Has document: No Adrian Griffin 13/08/2025 15:20	N		Review date: 12/11/2025 Is reviewed: No Adrian Griffin 13/08/2025 15:20
Capital Estates and Facilities	CEF - Capital PFI	CEF - Capital PFI/2023-2401	UHB PPP Expiry	08/11/2023	University Health Board PPP Expiry.	No plan in place to oversee the end of the PPP.	Lack of a plan to control the effects of the end of the PPP.	Team Meeting Board	20	Major	Almost Certain	Red	No joint expiry plan in place.	20	Major	Almost Certain	Red	No joint expiry plan in place.	4	Major	Highly Unlikely	Green	A joint plan including strong governance structure would provide assurance towards the end of the PPP.	Tolerate	End PFI project team to be formed. Has document: No Adrian Griffin 06/06/2025 11:23	None Specified. Has document: No Adrian Griffin 06/06/2025 11:23	None specified. Has document: No Adrian Griffin 06/06/2025 11:23	N		Review date: 05/09/2025 Is reviewed: No Adrian Griffin 06/06/2025 11:32
Capital Estates and Facilities	CEF - Capital PFI	CEF - Capital PFI/2023-2404	SDH End of PFI Agreement	15/11/2023	End of PFI. Signifficant resource need to oversee the planfor the end of the PFI agreement.	PFI ends 31/01/31 series of activities will be required.	Uncertainty of ongoing contract management	Team Meeting Board	20	Major	Almost Certain	Red	Potential for contract operational / disruption, if there is not a signifficant resource to oversee and plan for the end of the PFI agreement.	20	Major	Almost Certain	Red	Potential for contract operational / disruption, if there is not a signifficant resource to oversee and plan for the end of the PFI agreement.	4	Major	Highly Unlikely	Green	Ongoing contract management.	Tolerate	Series of activities required. Has document: No Adrian Griffin 08/04/2025 10:53	Separate risk register prepared to monitor all associated risks. Has document: No Adrian Griffin 08/04/2025 10:53	Risk increased to 20 to emphasise need to commence appointment and activities, especially with loss of PFI manager in April. Has document: No Adrian Griffin 08/04/2025 10:46	N		Review date: 13/10/2025 Is reviewed: No Adrian Griffin 09/06/2025 08:56 Review date: 04/07/2025 Is reviewed: Yes Adrian Griffin 04/04/2025 13:32
Capital Estates and Facilities	CEF - Capital PFI	CEF - Capital PFI/2023-2403	End of 3PD Agreement - Third Party Development	15/11/2023	End of 3PD Significant resource needed to oversee and plan for the end of agreement.	End of 3PD - 16/08/2027.	Uncertainty of ongoing contract management.	Team Meeting Board	20	Major	Almost Certain	Red	Potential for contract operational / disruption, if there is not a signifficant resource to oversee and plan for the end of the 3PD agreement.	20	Major	Almost Certain	Red	Potential for contract operational / disruption, if there is not a signifficant resource to oversee and plan for the end of the 3PD agreement.	4	Major	Highly Unlikely	Green	Ongoing contract management.	Tolerate	Series of activities required. Has document: No Adrian Griffin 08/04/2025 10:55	Separate risk register prepared to monitor all associated risks. Has document: No Adrian Griffin 08/04/2025 10:56	None provided Has document: No Adrian Griffin 08/04/2025 14:57	N		Review date: 04/07/2025 Is reviewed: No Adrian Griffin 04/04/2025 13:31
Capital Estates and Facilities	CEF - Capital PFI	CEF - Capital PFI/2023-2402	Saint Davids Hospital PFI Expiry	08/11/2023	Saint Davids Hospital PFI Expiry	No joint plan in place	No plan in place to oversee the end of the PFI	Team Meeting Board	20	Major	Almost Certain	Red	Lack of joint planning.	20	Major	Almost Certain	Red	Lack of joint planning.	4	Major	Highly Unlikely	Green	A joint plan including strong governance structure would oversee the end of the PFI.	Tolerate	End PFI project team to be formed. Has document: No Adrian Griffin 06/06/2025 10:39	None specified. Has document: No Adrian Griffin 06/06/2025 10:40	None specified. Has document: No Adrian Griffin 06/06/2025 10:40	N		Review date: 05/09/2025 Is reviewed: No Adrian Griffin 06/06/2025 10:48
Capital Estates and Facilities	CEF - Capital Property	CEF - Capital Property/2024-2501	Capital Property - WRP Cover of UHB Tenants	12/01/2024	WRP have cast doubt on whether they will indemnify the UHB against building risks traditionally offered by commercial insurance.	Financial Impact and Legal Impact. Plus potential loss of tenants.	Possible lack of buildings imsurance cover.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	In the event of a risk to a C&V building being realised, that causes signifficant damage WRP having cast doubt onthem indemnifying the cost of repairs/ rebuild if this is the case a signifficant financial burden may be realised upon C&V	20	Catastrophic	Highly Likely	Red	In the event of a risk to a C&V building being realised, that causes signifficant damage WRP having cast doubt onthem indemnifying the cost of repairs/ rebuild if this is the case a signifficant financial burden may be realised upon C&V	5	Catastrophic	Highly Unlikely	Green	WRP in ensuring indemnity will remove any additional financial burden upon C&V.	Tolerate	Ongoing discussions between NWSSP and WRP Has document: No Adrian Griffin 13/03/2025 15:31	Progress will be reported to relevant committees. Has document: No Adrian Griffin 13/03/2025 15:32	None provided Has document: No Adrian Griffin 13/03/2025 15:33	Y		Review date: 15/09/2025 Is reviewed: No Adrian Griffin 09/06/2025 08:54 Review date: 13/06/2025 Is reviewed: Yes Adrian Griffin 13/03/2025 15:43
Capital Estates and Facilities	CEF - Catering CFPU	CEF - Catering CFPU/2023-2401	Not Able to Maximise Stock Levels	19/12/2023	Not able to maximise stock levels to create a contingency stock level of frozen patient meals at the CFPU.	Unable to increase provisions of patient frozen meals to provide contingency levels. New food safety measures and controls required as identified by the food safety assurance manager requires a 4 hours blast freeze process compared to the previous 2 hours along with the new enzyme treatment shock treatment cleaning process takes 3 hours per day instead of previous 1 hour per day.	Financial impact: The need to purchase additional meals from an external company at an approximate cost of £25k monthly.	Team Meeting	20	Major	Almost Certain	Red	Unable to increase provisions of patient frozen meals to provide contingency levels. New food safety measures and controls required as identified by the food safety assurance manager requires a 4 hours blast freeze process compared to the previous 2 hours along with the new enzyme treatment shock treatment cleaning process takes 3 hours per day instead of previous 1 hour per day. Inadequate staff levels.	20	Major	Almost Certain	Red	Unable to increase provisions of patient frozen meals to provide contingency levels. New food safety measures and controls required as identified by the food safety assurance manager requires a 4 hours blast freeze process compared to the previous 2 hours along with the new enzyme treatment shock treatment cleaning process takes 3 hours per day instead of previous 1 hour per day. Inadequate staff levels.	4	Major	Highly Unlikely	Green	Rotas to be checked/reviewed and amended accordingly. Coninue to monitor production against patient demand, continue to be flexible with delivery schedules - continue to order limited products from external supplier to provide opportunity of increasing production.	Tolerate	Team Managers checking rotas off. Ensuring adequate staff levels maintained all areas covered. Overtime to be offered and the use of Bank staff to be utilised. Production maximised and cleaning regime completed as per instruction. Purchase meals from Apetito for additional stock items Has document: No Adrian Griffin 08/04/2025 11:07	Team managers/Supervisors monitoring weekly priority given to the 4 hour blast freeze process and the cleaning and enzyme treatments over the production requirements. - Assurance is provided ability to produce and the additional purchase of external meals. Has document: No Adrian Griffin 08/04/2025 11:08	Additional labour funding required to provide designated hygiene cleaning team allowing the current production staff to maximise production. Recognition of the additional cost of purchasing eternally. Has document: No Adrian Griffin 08/04/2025 11:08	N		Review date: 04/07/2025 Is reviewed: No Adrian Griffin 04/04/2025 13:31
Capital Estates and Facilities	CEF - Catering CFPU	CEF - Catering CFPU/2024-2501	Electrical Distribution - Potential Loss of Power	01/02/2024	CFPU are sitting on the outer HV ring, which isn't currently backed up by the HV generator, also without a local LV generator.	Current electrical back-up distribution system does support the CFPU in the event of a power failure.	Food production of patient cook freeze meals would stop. Large storage freezers and refrigeration holding high stock levels would fail to store frozen products at the correct temperature, stock levels of patient meals will need to be disposed of, this will compromise the ability to feed patients in line with Nutrition and hydration guidelines.	Team Meeting	20	Catastrophic	Highly Likely	Red	Food production of patient cook freeze meals would stop. Large storage freezers and refrigeration holding high stock levels would fail to store frozen products at the correct temperature, stock levels of patient meals will need to be disposed of, this will compromise the ability to feed patients in line with Nutrition and hydration guidelines.	20	Catastrophic	Highly Likely	Red	Food production of patient cook freeze meals would stop. Large storage freezers and refrigeration holding high stock levels would fail to store frozen products at the correct temperature, stock levels of patient meals will need to be disposed of, this will compromise the ability to feed patients in line with Nutrition and hydration guidelines.	5	Catastrophic	Highly Unlikely	Green	There has been limited occassions of power failure for the Lakeside complex where the CFPU is located. Manage stock levels to minimise stock loss, CEF to continue to review the risk.	Tolerate	The issue has been highlighted during the Power outage testing. CEF are aware. Has document: No Adrian Griffin 08/04/2025 11:16	There is limited reassurance due to the fact we have no location with large freezer space for the volume of meals. Has document: No Adrian Griffin 08/04/2025 11:11	A location for an external freezer/refrigeration space is required. A generator to supply the CFPU is prefered. Has document: No Adrian Griffin 08/04/2025 11:12	N		Review date: 08/09/2025 Is reviewed: No Adrian Griffin 09/06/2025 09:01 Review date: 04/06/2025 Is reviewed: Yes Adrian Griffin 04/04/2025 13:29
Capital Estates and Facilities	CEF - Catering CFPU	CEF - Catering CFPU/2024-2502	Potential Goods Lift Failure Service Impact	23/04/2024	CFPU is based on the first floor with one goods lift available - if the lift fails the transport of food provisions will be through an alternative route that is not conducive to a food safe environment. Aged equipment with parts no longer stocked - Risk of staff injury due to heavy handballing and lifting of products up stairways	Age of equipment, unavailability of parts.	Food production of patient cook freeze meals would stop, due to the ability to move high quantity heavy amounts (somedays 200 -300kg) fresh meat, chilled/frozen food in a food safe timescale. Increased level of staff injuries and possible claims.	Team Meeting	20	Catastrophic	Highly Likely	Red	The CFPU have no alternative lift avaiable.	20	Catastrophic	Highly Likely	Red	The CFPU have no alternative lift avaiable.	5	Catastrophic	Highly Unlikely	Green	Ideally the lift should be replaced. Ensuring that it is serviced regularly and parts are readily available. Contingency plan to be developed, mechanical aids available.	Tolerate	The issue has been highlighted during the lift failure 19/04/24. CEF are aware. Has document: No Adrian Griffin 08/04/2025 11:18	There is limited reassurance due to the fact we have no alternative lift avaiable other than increase the priority level for lift 46 any future repairs. Has document: No Adrian Griffin 08/04/2025 11:18	A location for an additional lift as contingenmcy or a suitable food safe route for food provisions Has document: No Adrian Griffin 08/04/2025 11:18	N		Review date: 06/10/2025 Is reviewed: No Adrian Griffin 09/06/2025 08:58 Review date: 04/07/2025 Is reviewed: Yes Adrian Griffin 04/04/2025 14:03

Capital Estates and Facilities	CEF - Compliance	CEF - Compliance/2023-2405	Fume Cabinet Inspections	11/10/2023	There is a risk of Service delivery, harm to staff, compliance with Authority Departments	This is caused by insufficient asset identification and lack of regular inspections and / or maintenance	Which w/could lead to an impact/effect on service delivery harm to staff using equipment.	Team Meeting	20	Catastrophic	Highly Likely	Red	Insufficient asset identification and lack of regular inspections and / or maintenance proof. Documentation required for Compliance authorities and to meet HTM requirements	20	Catastrophic	Highly Likely	Red	Insufficient asset identification and lack of regular inspections and / or maintenance proof. Documentation required for Compliance authorities and to meet HTM requirements	5	Catastrophic	Highly Unlikely	Green	Regular statutory inspections and support documentation in place	Treat	Inspections required with documentation held centrally Has document: No Tony Ward 28/08/2025 10:34		These assets are owned by end users. We are unsure of all known assets. Assets need to be collated, records recorded and kept in one location. This information has been requested on several occasions at the Ventilation Safety Group (VSG). Has document: No Tony Ward 28/08/2025 10:20	Y	The barrier for CEF is identification of a single source from each clinical board to provide this information. I have therefore put Robert Warren as responsible person as it seems a corporate issue. Status: Current Tony Ward 28/08/2025 10:26	Review date: 28/11/2025 Is reviewed: No Tony Ward 28/08/2025 10:49
Capital Estates and Facilities	CEF - Compliance	CEF - Compliance/2023-2402	Verification Smoke/Fire Dampers	01/12/2023	There is a risk that Insufficient asset identification and lack of regular inspections and / or maintenance resulting in defects leading to temporary or permanent failure. Potential for loss of service. Disruption to patient care. Danger of fire spread.	Assets not assetised at the time of installation. Asset identicication incomplete/inaccurate.	Which w/could lead to a potential for loss of service. Disruption to patient care. Danger of fire spread.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Insufficient asset identification and lack of regular inspections and / or maintenance resulting in defects leading to temporary or permanent failure. Potential for loss of service. Disruption to patient care. Danger of fire spread.	20	Catastrophic	Highly Likely	Red	Insufficient asset identification and lack of regular inspections and / or maintenance resulting in defects leading to temporary or permanent failure. Potential for loss of service. Disruption to patient care. Danger of fire spread.	5	Catastrophic	Highly Unlikely	Green	Remedial work carried out to provide access where possible. Note not all dampers will still not have access available after this process.	Tolerate	Assets are currently on long term contract arrangement with a single supplier for all UHB sites. Has document: No Adrian Griffin 13/08/2025 14:26	5 year contract in place. Started 1st Sept 2019. 3 + 1 + 1 year contract end date 1st Sept till 2024. 60% of dampers are being inspected annually. Has document: No Adrian Griffin 13/08/2025 14:26	Dampers 40% of dampers are not being serviced due to access issues. These range from no access hatched through to existing services prevent void access. Has document: No Adrian Griffin 13/08/2025 14:27	Y		Review date: 12/11/2025 Is reviewed: No Adrian Griffin 13/08/2025 14:28
Capital Estates and Facilities	CEF - Compliance	CEF - Compliance/2023-2404	Ventilation Smoke/Fire Dampers Dental Hospital UHW	01/12/2023	There is a risk that regular inspection and / or maintenance is not possible.	This is caused by the fire / smoke dampers are housed in ceiling void which is contaminated with Asbestos.	Which w/could lead to the potential for loss of service. Disruption to patient care. Danger of fire spread.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Regular inspection and / or maintenance is not possible as fire / smoke dampers are housed in ceiling void which is contaminated with Asbestos. Potential for loss of service. Disruption to patient care. Danger of fire spread.	20	Catastrophic	Highly Likely	Red	Regular inspection and / or maintenance is not possible as fire / smoke dampers are housed in ceiling void which is contaminated with Asbestos. Potential for loss of service. Disruption to patient care. Danger of fire spread.	5	Catastrophic	Highly Unlikely	Green	Continue with asbestos removal schemes to make area accessible.	Tolerate	The current drainage replacement programme involves clearing asbestos from the whole ceiling void on of a wing, one floor at a time. This will allow access to these areas. Has document: No Adrian Griffin 13/08/2025 14:42	Fire damper inspections will be carried when asbestos clearance has been completed. This will be done on a floor by floor basis. Has document: No Adrian Griffin 13/08/2025 14:43	Unable to complete until all floors have been made safe of asbestos. Has document: No Adrian Griffin 13/08/2025 14:43	N		Review date: 13/02/2026 Is reviewed: No Adrian Griffin 13/08/2025 14:44
Capital Estates and Facilities	CEF - Critical Risk Project	CEF - Critical Risk Project/2023-2403	UHW High Voltage Load Shedding Equipment	20/11/2023	The system relies on data provided by the Building Management System (BMS).	The system age is now not compatible with latest BMS installed	Failure of the system could result in no power being distributed to site. Failure could result in the overload of the generator and no power available. External parts could fail and not work correctly causing loss of power.	Team Meeting Board	25	Catastrophic	Almost Certain	Red	The system relies on external data from the building management system which is now old and newer systems available The system age is now not compatible with latest BMS installed Failure of the system could result in no power being distributed to site. Failure could result in overload of generator and no power available External parts could fail and not work correctly causing loss of power There is only one system no N+1 No simple override system Only know it's working when required to do so Only Authorised people high voltage (APs) able to remedy	25	Catastrophic	Almost Certain	Red	The system relies on external data from the building management system which is now old and newer systems available The system age is now not compatible with latest BMS installed Failure of the system could result in no power being distributed to site. Failure could result in overload of generator and no power available External parts could fail and not work correctly causing loss of power There is only one system no N+1 No simple override system Only know it's working when required to do so Only Authorised people high voltage (APs) able to remedy	5	Catastrophic	Highly Unlikely	Green	Upgrade existing system and associated equipment to latest standard Consideration of installation of backup system N+1 to allow maintenance and resilience in event of failure Look at simple override function (remote switching) Possibly move away from BMS control and move to independent system"	Tolerate	Operation POET conducted on September the 13th 2023 allowed full testing and analysis of the load shedding system. UHW conducted a total power outage from the mains that normally feeds the site, and engineers and technicians ensured the system functioned as it should. A contract with the provider BMSI is in place to maintain the system. Has document: No Adrian Griffin 17/07/2025 14:36	None specified. Has document: No Adrian Griffin 17/07/2025 14:37	None specified. Has document: No Adrian Griffin 17/07/2025 14:38	N		Review date: 16/10/2025 Is reviewed: No Adrian Griffin 17/07/2025 14:49
Capital Estates and Facilities	CEF - Critical Risk Project	CEF - Critical Risk Project/2024-2501	UHW Day Surgery Medical Air Compressors	04/12/2024	The plant is locatedwithin in a general plantroom. The plant is aged with repairs being carried out to keep it operable.	The location of the plant is unsuitable.	Non-conformity/ non-compliance - of plant due to its unsuitable location.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Failure of plant and equipment. Non comformity/ Non compliance due to the location of the compressor plant.	20	Catastrophic	Highly Likely	Red	Failure of plant and equipment. Non comformity/ Non compliance due to the location of the compressor plant.	5	Catastrophic	Highly Unlikely	Green	Plant and equipment replacement to improve performance - re-location of plant and equipment to ensurecomformity/ compliance.	Tolerate	Maintenance contract in place for repairs to plant. Has document: No Adrian Griffin 01/08/2025 13:33	None. Has document: No Adrian Griffin 01/08/2025 13:34	Unable to mitigate against non-compliance. Has document: No Adrian Griffin 01/08/2025 13:39	N		Review date: 31/10/2025 Is reviewed: No Adrian Griffin 01/08/2025 13:51
Capital Estates and Facilities	CEF - Critical Risk Project	CEF - Critical Risk Project/2024-2502	Cast Iron Above Ground Drainage Pipes	04/12/2024	Failure of cast iron pipes.	Age related cracking.	•Sewerage outfall at failure of pipes causing disruption to departments. •Internal bore restricted causing blockages •Damage to equipment and departments •Expensive repairs and clean ups to revenue budget	Team Meeting Board	20	Catastrophic	Highly Likely	Red	•Sewerage outfall at failure of pipes causing disruption to departments. •Internal bore restricted causing blockages •Damage to equipment and departments •Expensive repairs and clean ups to revenue budget	20	Catastrophic	Highly Likely	Red	•Sewerage outfall at failure of pipes causing disruption to departments. •Internal bore restricted causing blockages •Damage to equipment and departments •Expensive repairs and clean ups to revenue budget	5	Catastrophic	Highly Unlikely	Green	Replacement program initiated to cover essential areas or problematic areas by priority.	Tolerate	•Replacement program for main ward blocks Has document: No Adrian Griffin 29/07/2025 15:09	•Repairs can be carried out at point of failure Has document: No Adrian Griffin 29/07/2025 15:10	None provided. Has document: No Adrian Griffin 29/07/2025 15:10	N		Review date: 28/10/2025 Is reviewed: No Adrian Griffin 29/07/2025 15:17
Capital Estates and Facilities	CEF - Critical Risk Project	CEF - Critical Risk Project/2024-2503	2 Cold/ Hot Water Storage Tanks - CHFW	01/12/2024	Tank or Tanks Failure.	Loss of water supply Cold/ Hot to CHFW Phase 1.	•Failure of a tank or tanks leading to loss of water supply hot and cold to CHFW Phase 1. •Tanks not being turned over in 12 hours meaning over capacity and not compliant with Guidance. •Tanks serve both services hot and cold any issues result in both services being affected. •Tanks 24 years old life expectancy is 25 years •Tanks physically joined together and not wholly independent. •Access ladder non-compliant.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	•Failure of a tank or tanks leading to loss of water supply hot and cold to CHFW Phase 1. •Tanks not being turned over in 12 hours meaning over capacity and not compliant with Guidance. •Tanks serve both services hot and cold any issues result in both services being affected. •Tanks 24 years old life expectancy is 25 years. •Tanks physically joined together and not wholly independent. •Access ladder non-compliant.	20	Catastrophic	Highly Likely	Red	•Failure of a tank or tanks leading to loss of water supply hot and cold to CHFW Phase 1. •Tanks not being turned over in 12 hours meaning over capacity and not compliant with Guidance. •Tanks serve both services hot and cold any issues result in both services being affected. •Tanks 24 years old life expectancy is 25 years. •Tanks physically joined together and not wholly independent. •Access ladder non-compliant.	5	Catastrophic	Highly Unlikely	Green	•Replacement of tanks would ensure compliance to current standards. •Two independent tanks fitted/ sized correctly. •Accedd ladder upgraded.	Tolerate	•Chlorine dioxide plant feeding tanks reducing legionella and pseudomonas risk to system. Has document: No Adrian Griffin 28/07/2025 15:29	•2 tanks normally available for resilience. Has document: No Adrian Griffin 28/07/2025 15:29	None provided. Has document: No Adrian Griffin 28/07/2025 15:30	N		Review date: 27/10/2025 Is reviewed: No Adrian Griffin 28/07/2025 15:38
Capital Estates and Facilities	CEF - Critical Risk Project	CEF - Critical Risk Project/2024-2504	Main 415v Distribution Panel - UHW	01/12/2024	Loss of power.Leading to the disruption to the electrical distribution system.	Due to Age of equipment.	•Live terminals exposed RISK OF ELECTROCUTION. •Whole distribution board requires shut down, to work on system. •Parts not readily available, adaptations would need to be completed to make a repair. •No overload protection only rewireable fuses. •No expansion available without add on board.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	•Failure of Board due to age. • Area left without mains power. •Live terminals exposed RISK OF ELECTROCUTION. •Whole board, requires shut down to work on system. •Parts not readily available adaptations would need to be completed to make a repair.	20	Catastrophic	Highly Likely	Red	•Failure of Board due to age. • Area left without mains power. •Live terminals exposed RISK OF ELECTROCUTION. •Whole board, requires shut down to work on system. •Parts not readily available adaptations would need to be completed to make a repair.	5	Catastrophic	Highly Unlikely	Green	•Installation of new distribution board and cabling. •New distribution board built to modern standard, cable to all outgoing services, ensuring appropriate circuit protection.Review overall installation for suitability.	Tolerate	•No mitigation against failure. •Warning notices to be fitted. •Qualified competent electrician only to work on system. Has document: No Adrian Griffin 28/07/2025 14:51	None provided. Has document: No Adrian Griffin 28/07/2025 14:52	No mitigation against failure. Has document: No Adrian Griffin 28/07/2025 14:52	N		Review date: 27/10/2025 Is reviewed: No Adrian Griffin 28/07/2025 15:06
Capital Estates and Facilities	CEF - Critical Risk Project	CEF - Critical Risk Project/2024-2505	UHW 11KV Mains Distribution Board - Site Network	01/12/2024	There are no additional spare circuits for any further expansion. Any additional substations are added to existing circuits adding to their criticality and reliance. Fault with board causing loss of power to hospital Breakers are SF6 (Sulphur hexafluoride) ozone depleting gas	Unsure of the availability of replacement parts due to age and Gas type (Sulphur hexafluoride)	All the electrical intake equipment is in one location, feeding the whole of hospital, risk to loss from fire would mean total loss.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	•There are no additional spare circuits for any further expansion. Any additional substations are added to existing circuits adding to their criticality and reliance. •Fault with board causing loss of power to hospital •Breakers are SF6 (Sulphur hexafluoride) ozone depleting gas. •Unsure of replacement parts due to age and Gas type •Only Authorised people able to switch equipment	20	Catastrophic	Highly Likely	Red	•There are no additional spare circuits for any further expansion. Any additional substations are added to existing circuits adding to their criticality and reliance. •Fault with board causing loss of power to hospital •Breakers are SF6 (Sulphur hexafluoride) ozone depleting gas. •Unsure of replacement parts due to age and Gas type •Only Authorised people able to switch equipment	5	Catastrophic	Highly Unlikely	Green	The Controlled replacement, modification and or expansion to the main 11kv distribution board, will provide the necessary assurance of continuity for the supply of electricity at the University Hospital of Wales.	Tolerate	•Able to split board and feed from other half of board •Contract with specialist contractors for maintenance •Trained staff and competent staff on call 24/7 •Full alarm system and regular maintenance Has document: No Adrian Griffin 28/07/2025 13:58	"•Undertake independent review and seek advice off Authorizing Engineer on level of Risk •Consider sourcing spares •Review upgrade options •Look at extension of existing board •Look at having back up emergency arrangements away from existing building." Has document: No Adrian Griffin 28/07/2025 14:01	None recorded. Has document: No Adrian Griffin 28/07/2025 14:01	N		Review date: 27/10/2025 Is reviewed: No Adrian Griffin 28/07/2025 14:16
Capital Estates and Facilities	CEF - Critical Risk Project	CEF - Critical Risk Project/2023-2401	UHW Blowdown vessel of main steam boilers	01/12/2023	Operational difficulty in controlling quality of boiler water	Plant/equipment age - deterioration	•Failure to meet pressure vessel regulations (subject to defect notice) •Contravention for water discharge permit by Welsh water •Scalding risk •Isolation vales showing signs of wear •Age of vessel beyond working life	Team Meeting Board	20	Catastrophic	Highly Likely	Red	•Operational difficulty in controlling quality of boiler water •Failure to meet pressure vessel regulations (subject to defect notice) •Contravention for water discharge permit by Welsh water •Scalding risk •Isolation vales showing signs of wear •Age of vessel beyond working life	20	Catastrophic	Highly Likely	Red	•Operational difficulty in controlling quality of boiler water •Failure to meet pressure vessel regulations (subject to defect notice) •Contravention for water discharge permit by Welsh water •Scalding risk •Isolation vales showing signs of wear •Age of vessel beyond working life	5	Catastrophic	Highly Unlikely	Green	•Suggest new vessel and associated valves replaced •Repair existing vessel and controls to comply •Improve PPMS and reporting procedures •Carry out remedial maintenance works	Tolerate	•Discharge water pipe repaired and replaced by estates recently to prevent boiling water being exhausted through vent (actual event) •Approved people in boiler house and trained Has document: No Adrian Griffin 18/07/2025 11:45	None specified. Has document: No Adrian Griffin 18/07/2025 11:46	None specified. Has document: No Adrian Griffin 18/07/2025 11:46	N		Review date: 17/10/2025 Is reviewed: No Adrian Griffin 18/07/2025 11:50
Capital Estates and Facilities	CEF - Critical Risk Project	CEF - Critical Risk Project/2023-2402	UHW Pumped Cold Water Mains to Roof Tanks	22/11/2023	Unable to supply cold water to roof tanks.	Failure of pipework (resilience). Age of original pipe and number of previous repairs. +1 Pipe is now approximately 20 years old. Both pipes converge into one riser (single point of failure) Diosruption to site when failure occurs. Treated water (chlorine dioxide) not supplied in the event of total failure. Labour intensive to resolve.	Cold water supply unavailable. Affecting operational capabilities.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	•Failure of pipework (resilience). •Unable to supply cold water to roof tanks. •Age of original pipe and number of repairs. •+1 pipe is now approximately 20 years old. •Both pipes converge into one riser (single point failure). •Disruption to site when failure occurs.	20	Catastrophic	Highly Likely	Red	•Failure of pipework (resilience). •Unable to supply cold water to roof tanks. •Age of original pipe and number of repairs. •+1 pipe is now approximately 20 years old. •Both pipes converge into one riser (single point failure). •Disruption to site when failure occurs.	5	Catastrophic	Highly Unlikely	Green	•Plan to replace original pipe with modern materials and jointing techniques. •Look at secondary riser either full bore or emergency capacity. •Look at life cycle of +1 and plan replacement"	Tolerate	"•N+1 installed one can supply the site •Contractors usually effect repair within 2 days •Pipes separated for most of run minimizing accidental damage, or subsidence. •+1 installed within 20 years •Alternative supply available in LGF (untreated)" Has document: No Adrian Griffin 18/07/2025 11:15	None specified. Has document: No Adrian Griffin 18/07/2025 11:16	None specified. Has document: No Adrian Griffin 18/07/2025 11:16	N		Review date: 17/10/2025 Is reviewed: No Adrian Griffin 18/07/2025 11:23
Capital Estates and Facilities	CEF - Electrical	CEF - Electrical/2025-2602	UHW LGF Switch Room 4	09/06/2025	UHW LGF switch room 4 suffers from water ingression, that as a potential to cause harm / loss of electrical supply.	Water ingression and damp, due to leaking valves and the humidity within the room.	The electrical switch gear is suffering from corrosion and standing water, water dripping off leaking valves which is an electrocution risk to operatives.	Team Meeting Board	25	Catastrophic	Almost Certain	Red	UHW LGF switch room 4 suffers from water ingression and damp, due to the humidity within the room the electrical switch gear is suffering corrosion and standing water, water dripping off leaking valves is an electrocution risk to operatives.	25	Catastrophic	Almost Certain	Red	UHW LGF switch room 4 suffers from water ingression and damp, due to the humidity within the room the electrical switch gear is suffering corrosion and standing water, water dripping off leaking valves is an electrocution risk to operatives.	5	Catastrophic	Highly Unlikely	Green	Redesign of the mechanical services and electrical infrastructure required to improve reliability and resilience.	Tolerate	Estates are aware of the issues Has document: No Adrian Griffin 12/08/2025 15:32	Discretionary Capital will look at the cause and rectify , add suitable drainage, switch gear replacement. Has document: No Adrian Griffin 12/08/2025 15:33	None specified. Has document: No Adrian Griffin 12/08/2025 15:33	Y		Review date: 11/11/2025 Is reviewed: No Adrian Griffin 12/08/2025 15:34
Capital Estates and Facilities	CEF - Electrical	CEF - Electrical/2024-2505	Reliance on High Voltage generation for critical services.	02/12/2024	There is a risk of reliance on HV generation for critical resources across the health board.	This is caused by the need for a stand by source of electrical power generation in the event of a mains power failure.	Failure of the second source of electrical power distribution (HV generation).	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Reliance on HV generator for critical services	20	Catastrophic	Highly Likely	Red	Reliance on HV generator for critical services	5	Catastrophic	Highly Unlikely	Green	Redesign of the electrical infrastructure will improve reliability and resilience.	Tolerate	On call Estates Staff are aware of the issue and will attend as a priority in the event of a power loss. Has document: No Adrian Griffin 12/08/2025 15:00	Redesign of the electrical infrastructure required to improve reliability and resilience. Has document: No Adrian Griffin 12/08/2025 15:01	None specified. Has document: No Adrian Griffin 12/08/2025 15:01	N		Review date: 11/11/2025 Is reviewed: No Adrian Griffin 12/08/2025 15:05

Capital Estates and Facilities	CEF - Electrical	CEF - Electrical/2024-2502	UHW Lifts urgently require replacement	02/12/2024	There is a risk that site lifts will fail, causing operational failures.	The age of the lifts/ wear and tear and high usage.	Which could lead to an impact on patient, staff and public movement across the UHW estate.	Team Meeting Board	20	Major	Almost Certain	Red	Lifts urgently require replacement. A phased approach has been adopted with the following lifts to be reviewed: Maternity Lifts 8 & 9 All to be considered. Impact: Failure of lifts restricts public and staff movement around site. Lifts 1, 2,5,6,12,13,14,15,16,17,18,19,20,21,22, 23,24 & 27. Failure of lifts restricts public and staff movement around site	20	Major	Almost Certain	Red	Lifts urgently require replacement. A phased approach has been adopted with the following lifts to be reviewed: Maternity Lifts 8 & 9 All to be considered. Impact: Failure of lifts restricts public and staff movement around site. Lifts 1, 2,5,6,12,13,14,15,16,17,18,19,20,21,22, 23,24 & 27. Failure of lifts restricts public and staff movement around site	4	Major	Highly Unlikely	Green	Lift replacements will ensure improved performance / operability. Replacements will ensure that the patients, staff and visitors can travel impeded between floors.	Tolerate	Maintained on a best endeavours philosophy until scheme to replace these lifts is conducted. Has document: No Adrian Griffin 12/08/2025 10:45	The UHB has an annual testing program in place that inspects all lifts. These lifts require major overhaul and upgrade to latest standards. Has document: No Adrian Griffin 12/08/2025 10:45	Some parts are likley to become obsolete whilst waiting for upgrades. Has document: No Adrian Griffin 12/08/2025 10:46	Y		Review date: 11/11/2025 Is reviewed: No Adrian Griffin 12/08/2025 10:48
Capital Estates and Facilities	CEF - Electrical	CEF - Electrical/2024-2503	Electrical sub station 2A - auto changeover fail.	02/12/2024	The automatic changeover for electrical sub station 2A is not functioning. Maintenance and re-testing has been carried out on numerous times however the fault persists.	The equipment cannot be directlty replaced due to the age of the switchgear and replacement parts being obsolete.	In the event of an unplanned power outage the changeover system will not work and will require manual switching by Estates staff. Sub 2A provides power for a number of essential areas incluidng Main Operating Theatres, recovery, SDEC, Mortuary, Cath labs A B and C, sections of the LGF tunnels and other essential plant.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	In the event of an unplanned power outage the changeover system will not work and will require manual switching by Estates staff. Sub 2A provides power for a number of essential areas incluidng Main Operating Theatres, recovery, SDEC, Mortuary, Cath labs A B and C, sections of the LGF tunnels and other essential plant.	20	Catastrophic	Highly Likely	Red	In the event of an unplanned power outage the changeover system will not work and will require manual switching by Estates staff. Sub 2A provides power for a number of essential areas incluidng Main Operating Theatres, recovery, SDEC, Mortuary, Cath labs A B and C, sections of the LGF tunnels and other essential plant.	5	Catastrophic	Highly Unlikely	Green	Redesign and installation of the electrical infrastructure will improve reliability and resilience.	Tolerate	On call Estates Staff are aware of the issue and will attend as a priority in the event of a power loss. Has document: No Adrian Griffin 12/08/2025 13:35	Discretionary Capital will start the Design and Tender process to enable funding to be sought from Welsh Government for replacement of the equipment. Has document: No Adrian Griffin 12/08/2025 13:36	Obsolete parts unavailable in the short term until replacement project can be undertaken. Has document: No Adrian Griffin 12/08/2025 13:37	N		Review date: 11/11/2025 Is reviewed: No Adrian Griffin 12/08/2025 13:42
Capital Estates and Facilities	CEF - Energy & Environment	CEF - Energy & Environment/2025-2602	Energy Cost Pressures - instability within the energy markets.	14/08/2025	There is a risk that the Energy Markets are very unstable which is resulting in dramatic tariff increases for the remainder of 21/22 and for the entire 22/23 financial year. Estimated cost pressures are £2.1 million for 21/22 and £4.6 million for 22/23 (total estimated expenditure is therefore £15 million).	War in the Ukraine, energy costs in general, uncertainty in the energy markets.	The increase in costs, causing an additional drain on the annual overall health board budget.	Team Meeting Board	25	Catastrophic	Almost Certain	Red	Energy Cost pressures. Energy Markets are very unstable which is resulting in dramatic tariff increases for the remainder of 21/22 and for the entire 22/23 financial year. Estimated cost pressures are £2.1 million for 21/22 and £4.6 million for 22/23 (total estimated expenditure is therefore £15 million).	25	Catastrophic	Almost Certain	Red	Energy Cost pressures. Energy Markets are very unstable which is resulting in dramatic tariff increases for the remainder of 21/22 and for the entire 22/23 financial year. Estimated cost pressures are £2.1 million for 21/22 and £4.6 million for 22/23 (total estimated expenditure is therefore £15 million).	5	Catastrophic	Highly Unlikely	Green	It is hoped that stability will eventually return to the energy markets. Solar energy/ energy upgrade project improvements coming onto stream, decreasing the requirement to purchase external electrical energy and lowering the demand for gas through improved insulation, window replacements etc.	Tolerate	Energy spend monitored and reported to Finance department monthly and is further supported by monthly meetings Has document: No Adrian Griffin 14/08/2025 14:51	Energy spend monitored and reported to Finance department monthly and is further supported by monthly meetings Has document: No Adrian Griffin 14/08/2025 14:51	None specified. Has document: No Adrian Griffin 14/08/2025 14:51	N		Review date: 13/11/2025 Is reviewed: No Adrian Griffin 14/08/2025 14:52
Capital Estates and Facilities	CEF - Energy & Environment	CEF - Energy & Environment/2025-2603	IT Connectivity	15/08/2025	There is a financial risk associated with the delay in bringing Ph 2 and Ph3 of the energy refit on stream.	IT connectivity required to complete the existing and current solar installations. Allowing for them to be brought on stream.	Which has lead to cost savings being delayed. These cost savings would reduce the annual energy bill.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	The longer the delay in connectivity, the loss of significant monetary savings. These savings would go towards ensuring budget constraints are met.	20	Catastrophic	Highly Likely	Red	The longer the delay in connectivity, the loss of significant monetary savings. These savings would go towards ensuring budget constraints are met.	5	Catastrophic	Highly Unlikely	Green	IT connectivity would ensure the completion of Ph.2/3 of the refit program. Solar being brought on stream and financial savings made.	Tolerate	Refit phases 2 and 3 have meetings with contractor and IT weekly to resolve. Has document: No Adrian Griffin 15/08/2025 09:42	Assurances are through monthly reporting and meetings with finance. Has document: No Adrian Griffin 15/08/2025 09:43	None provided. Has document: No Adrian Griffin 15/08/2025 09:47	N		Review date: 14/11/2025 Is reviewed: No Adrian Griffin 15/08/2025 09:50
Capital Estates and Facilities	CEF - Energy & Environment	CEF - Energy & Environment/2025-2604	Combined Heating and Power Plant (CHP)	28/02/2025	There is a risk that UHW CHP Plant current O and M contract with Clarke Energy will expire in April 2025. Current CHP plant has exceeded 90,000 run hours requiring major overhaul / upgrade or plant replacment.	This is caused by the end of the current contract.	As the CHP plant provides significant revenue savings and forms a significant element of the heating and electricity infrastructure, plant failure will result in operational difficulties. Current contract states that plant failure risk lies with the UHB	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Which could impact/effect on the operation, maintenance and servicing of the CHP equipment.	20	Catastrophic	Highly Likely	Red	Current CHP plant has exceeded 90,000 run hours requiring major overhaul / upgrade or plant replacment. As the CHP plant provides significant revenue savings and forms a significant element of the heating and electricity infrastructure, plant failure will result in operational difficulties. Current contract states that plant failure risk lies with the UHB	5	Catastrophic	Highly Unlikely	Green	A contract/ temporary contract agreement would provide reassurance with regards to the operation, maintenance and servicing of the CHP equipment.	Tolerate	Current O and M contract is in place until April 2025. Internal discussions are being held to develop propsed solutions. Has document: No Adrian Griffin 15/08/2025 11:06	Controls are through Departmental Assurance meetings, Team Brief and discussions with Clarke Energy. Has document: No Adrian Griffin 15/08/2025 11:07	CHP plant upgrade/replacement is required. Has document: No Adrian Griffin 15/08/2025 11:19	N		Review date: 14/11/2025 Is reviewed: No Adrian Griffin 15/08/2025 11:07
Capital Estates and Facilities	CEF - Energy & Environment	CEF - Energy & Environment/2025-2606	UHW Increased water consumption	01/07/2025	There is a risk that UHW Water Consumption Water consumption is increasing.	This is attributed to leaks and unexplained usage.	This is resulting in water wastage and excessive costs.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	UHW Water Consumption Water consumption is increasing attributed to leaks and unexplained usage. This is resulting in water wastage and excessive costs.	20	Catastrophic	Highly Likely	Red	UHW Water Consumption Water consumption is increasing attributed to leaks and unexplained usage. This is resulting in water wastage and excessive costs.	8	Major	Unlikely	Amber	Water consumption decreased due to infrastructure repairs.	Treat	Water studies and leakage detection surveys are in progress to determine the scale of the leakage and the location(s) of the leaks. Has document: No Adrian Griffin 15/08/2025 11:55	Meeting being carried out each week between Estates, Energy Team and Enica along with other stakeholders to monitor progress. Updates are provided to senior leadership team fortnightly. Has document: No Adrian Griffin 15/08/2025 11:56		Y		Review date: 14/11/2025 Is reviewed: No Adrian Griffin 15/08/2025 12:02
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2024-2505	CRI Main Boiler Plant - High Levels of Corrosion	02/12/2024	The boilers in the main plantroom at CRI are suffering from high levels of corrosion.	Upon investigation the general opinion from two seperate contracting companies was, that this corrosion is due to compromised gaskets in the double skin of the flue itself.	Temperature control is proving difficult. The leak on the flue is also a concern for the offering a source of combustion in the plantroom. (Due to fears around the integrity of the flue).	Team Meeting Board	20	Major	Almost Certain	Red	The boilers in the main plantroom CRI are suffering from high levels of corrosion, the leak was originally suspected to be from an ingress of rain water. Upon investigation the general opinion from two seperate contracting companies was that the corrosion is due to compromised gaskets in the double skin of the flue itself.	20	Major	Almost Certain	Red	The boilers in the main plantroom CRI are suffering from high levels of corrosion, the leak was originally suspected to be from an ingress of rain water. Upon investigation the general opinion from two seperate contracting companies was that the corrosion is due to compromised gaskets in the double skin of the flue itself.	4	Major	Highly Unlikely	Green	Repair/ replace - A Report has been submitted to Dis/Capital advising of the cause of the corrosion and recommendations to correct the issue.	Tolerate	Leak diversion set up. Has document: No Adrian Griffin 19/08/2025 11:34	The secondary assurance is that of the ongoing protection of the boilers to prevent further deterioration. Has document: No Adrian Griffin 19/08/2025 11:37	None specified. Has document: No Adrian Griffin 19/08/2025 11:38	N		Review date: 18/11/2025 Is reviewed: No Adrian Griffin 19/08/2025 11:38
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2025-2613	CHFW Ph 2 MRI Unit Scaleformation, Corrosion, Biological Growth	24/03/2025	Poor industrial water quality.	This is caused by : Scale Formation, Corrosion, Biological Growth, Sedimentation	Energy Impact of Poor Industrial Water Quality a chiller operating with scaled heat exchangers can consume up to 30% more energy to provide the same amount of cooling.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Scale Formation, Corrosion, Biological Growth, Sedimentation Energy Impact of Poor Industrial Water Quality a chiller operating with scaled heat exchangers can consume up to 30% more energy to provide the same amount of cooling as a system with clean surfaces. This not only increases operational costs but also places a greater strain on the facility's energy resources.	20	Catastrophic	Highly Likely	Red	Scale Formation, Corrosion, Biological Growth, Sedimentation Energy Impact of Poor Industrial Water Quality a chiller operating with scaled heat exchangers can consume up to 30% more energy to provide the same amount of cooling as a system with clean surfaces. This not only increases operational costs but also places a greater strain on the facility's energy resources.	5	Catastrophic	Highly Unlikely	Green	By ensuring high water quality, facilities can optimize the performance of their chilled water systems, leading to significant energy savings and reduced operational costs Equipment Damage and Shortened Lifespan- Chiller failure	Tolerate	None provided. Has document: No Adrian Griffin 20/08/2025 11:20	None provided. Has document: No Adrian Griffin 20/08/2025 11:20	None provided. Has document: No Adrian Griffin 20/08/2025 11:21	N		
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2025-2615	CHFW P2 Main Chiller Scale Formation, Corrosion, Biological Growth,	13/02/2025	Poor industrial water quality.	This is caused by: Scale Formation, Corrosion, Biological Growth, Sedimentation.	Poor Industrial Water Quality a chiller operating with scaled heat exchangers can consume up to 30% more energy to provide the same amount of cooling.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Scale Formation, Corrosion, Biological Growth, Sedimentation Energy Impact of Poor Industrial Water Quality a chiller operating with scaled heat exchangers can consume up to 30% more energy to provide the same amount of cooling as a system with clean surfaces. This not only increases operational costs but also places a greater strain on the facility's energy resources.	20	Catastrophic	Highly Likely	Red	Scale Formation, Corrosion, Biological Growth, Sedimentation Energy Impact of Poor Industrial Water Quality a chiller operating with scaled heat exchangers can consume up to 30% more energy to provide the same amount of cooling as a system with clean surfaces. This not only increases operational costs but also places a greater strain on the facility's energy resources.	5	Catastrophic	Highly Unlikely	Green	By ensuring high water quality, facilities can optimize the performance of their chilled water systems, leading to significant energy savings and reduced operational costs Equipment Damage and Shortened Lifespan - Chiller failure.	Tolerate	None provided. Has document: No Adrian Griffin 20/08/2025 11:41	None provided. Has document: No Adrian Griffin 20/08/2025 11:41	None provided. Has document: No Adrian Griffin 20/08/2025 11:41	N		Review date: 19/11/2025 Is reviewed: No Adrian Griffin 20/08/2025 11:44
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2025-2616	Radiology Plantroom Main Chillers	24/03/2025	Poor industrial water quality.	This is caused by: Scale Formation, Corrosion, Biological Growth, Sedimentation.	Energy Impact of Poor Industrial Water Quality a chiller operating with scaled heat exchangers can consume up to 30% more energy to provide the same amount of cooling.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Scale Formation, Corrosion, Biological Growth, Sedimentation. Energy Impact of Poor Industrial Water Quality a chiller operating with scaled heat exchangers can consume up to 30% more energy to provide the same amount of cooling as a system with clean surfaces. This not only increases operational costs but also places a greater strain on the facility's energy resources.	20	Catastrophic	Highly Likely	Red	Scale Formation, Corrosion, Biological Growth, Sedimentation. Energy Impact of Poor Industrial Water Quality a chiller operating with scaled heat exchangers can consume up to 30% more energy to provide the same amount of cooling as a system with clean surfaces. This not only increases operational costs but also places a greater strain on the facility's energy resources.	5	Catastrophic	Highly Unlikely	Green	By ensuring high water quality, facilities can optimize the performance of their chilled water systems, leading to significant energy savings and reduced operational costs Equipment Damage and Shortened Lifespan- Chiller failure.	Tolerate	None provided. Has document: No Adrian Griffin 20/08/2025 13:15	None p[rovided. Has document: No Adrian Griffin 20/08/2025 13:15	None provided. Has document: No Adrian Griffin 20/08/2025 13:15	N		Review date: 19/11/2025 Is reviewed: No Adrian Griffin 20/08/2025 13:16
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2025-2618	UHW Pharmacy Hoist Aged Equipment.	25/03/2025	Several failures of Pharmacy hoist (dumb waiter).	Age of equipment. Parts are obsolete.	Operational impact. Leading to difficulties in the transfer of goods.	Team Meeting Board	20	Major	Almost Certain	Red	Due to age of equipment, several failures of Pharmacy hoist (dumb waiter) parts are obsolete.	20	Major	Almost Certain	Red	Due to age of equipment, several failures of Pharmacy hoist (dumb waiter) parts are obsolete. Does not meet current safety standards and replacement quote for a new lift is £50k.	4	Major	Highly Unlikely	Green	Complete renewal / modernisation.	Tolerate	None specified. Has document: No Adrian Griffin 20/08/2025 13:36	None specified. Has document: No Adrian Griffin 20/08/2025 13:36	None specified. Has document: No Adrian Griffin 20/08/2025 13:36	N		Review date: 19/11/2025 Is reviewed: No Adrian Griffin 20/08/2025 13:37
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2025-2619	Fire Fighting Lift Control	26/03/2025	18 Fire fighting or Evacuation lifts require annual testing and inspection throughout CAVUHB 2 at Barry, 6 at UHL and 10 at UHW.	This has not been done previously (no record if it has).	This was noted in the LOLER inspections for firefighting lifts.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	18 Fire fighting or Evacuation lifts require annual testing and inspection throughout CAVUHB 2 at Barry, 6 at UHL and 10 at UHW This has not been done previously (no record if it) It is not contained within the all Wales contract for lifts (OTIS is the contracted company). This was noted in the LOLER inspections for firefighting lifts.	20	Catastrophic	Highly Likely	Red	18 Fire fighting or Evacuation lifts require annual testing and inspection throughout CAVUHB 2 at Barry, 6 at UHL and 10 at UHW This has not been done previously (no record if it) It is not contained within the all Wales contract for lifts (OTIS is the contracted company). This was noted in the LOLER inspections for firefighting lifts. Funding required.	5	Catastrophic	Highly Unlikely	Green	Annual testing being carried out to ensure compliance.	Tolerate	None specified. Has document: No Adrian Griffin 20/08/2025 14:55	None specified. Has document: No Adrian Griffin 20/08/2025 14:55	None specified. Has document: No Adrian Griffin 20/08/2025 14:55	N		Review date: 19/11/2025 Is reviewed: No Adrian Griffin 20/08/2025 14:56
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2025-2611	Fire Doors Require Replacing	07/04/2025	Fire doors identified as requiring replacement , due to condition of the doors not meeting fire requirements.	Fire doors. Non Compliant.	Door will not perform in accordance with standards in the event of fire, thus not containing the spread of fire and putting patients staff , visitors and property at risk.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Delays in carrying out the replacement of non compliant doors	20	Catastrophic	Highly Likely	Red	Delays in carrying out the replacement of non compliant doors	5	Catastrophic	Highly Unlikely	Green	The replacement of non compliant doors will ensure complaiance to the relevant standard/s. ensuring improved fire safety across the estate.	Tolerate	Door inspected weekly as part of a PPM by estates staff Has document: No Adrian Griffin 08/04/2025 11:19	Inspection results recorded Has document: No Adrian Griffin 08/04/2025 11:20	Doors identified as not been compliant LGF Central link doors 237 x 2, LGF PLANT ROOM 3 No 143 x 2, LGF Dental No 14 x 2, LGF Medical Records No 317 new doors required, LGF Pembroke 330, 341N, 341, 343, 345, 346, 360 all require replacing, LGF Lakeside No 317 x 2, 359, 330, 331, 335A, LGF Outpatients rear exit doors. Has document: No Adrian Griffin 08/04/2025 11:20	N		Review date: 08/11/2025 Is reviewed: No Adrian Griffin 04/08/2025 13:21 Review date: 08/08/2025 Is reviewed: Yes Adrian Griffin 09/06/2025 09:01 Review date: 07/07/2025 Is reviewed: Yes Adrian Griffin 07/04/2025 10:46

Capital Estates and Facilities	CEF - Estates	CEF - Estates/2022-2301	Medical Gas Safety PRV Equipment	31/12/2022	Medical Gas safety PRV, equipment and Gauges unable to test and carry out inspection or change.	Obsolete equipment and currently out of compliance with overdue unspection.	Unable to isolate equipment supplying critical parts of the hospital.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	No specific control for this equipment, only visual inspection.	20	Catastrophic	Highly Likely	Red	No specific control for this equipment, only visual inspection.	5	Catastrophic	Highly Unlikely	Green	Plan in place to incorporate the difficulties in changing obsolete and live working safety valves and obsolete PRV /GAUGES whilst maintaining the med gas supplies.	Tolerate	Visual inspection only. Has document: No Adrian Griffin 09/04/2025 11:17	Equipment checks. Has document: No Adrian Griffin 09/04/2025 11:20	Unable to isolate equipment supplying critical parts of the hospital. Has document: No Adrian Griffin 09/04/2025 11:22	N		Review date: 31/10/2025 Is reviewed: No Adrian Griffin 09/04/2025 11:29
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2022-2305	No Authorising Engineer Assigned to Lifts	07/12/2022	With no Authorising Engineer assigned to Lifts, we are unable to appoint Lift AP's and carry out Audits on Lift condition & management systems etc	Unavailability of lift Authorising Engineer.	Unable to carry out Audits on Lift condition & management systems etc.	Team Meeting Audit and Assurance Committee	20	Major	Almost Certain	Red	With no Authorising Engineer assigned to Lifts, we are unable to appoint Lift AP's and	20	Catastrophic	Highly Likely	Red	With no Authorising Engineer assigned to Lifts, we are unable to appoint Lift AP's and	4	Major	Highly Unlikely	Green	The appointment of a Authorising Engineer will allow for the appointment of AP's to carry out Audits on Lift condition & management systems etc	Tolerate	Reliant on training that has been provided at Eastwood Park. Lift engineer to manage the lift system. Has document: No Adrian Griffin 09/04/2025 11:55	No incidents recorded, the system is managed to the correct standard using OTIS contractor & statutory inspection. Has document: No Adrian Griffin 09/04/2025 11:56	System managed, trained but not appointed formally. Has document: No Adrian Griffin 09/04/2025 11:57	N		Review date: 03/11/2025 Is reviewed: No Adrian Griffin 04/08/2025 13:25 Review date: 31/08/2025 Is reviewed: Yes Adrian Griffin 09/04/2025 13:45
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2023-2407	Auto changeover system - On loss of power to LV sub A1 panel	29/07/2023	Auto Changeover system - On loss of power to LV sub A1 panel, ACB failed to take secondary supply system (SPS generator backup) ACB failed to take load on 3 separate attempts of testing – on all occasions ACB fired through.	Failure to provide on distribution strategies standby generators resilience of N+1 automatically.	Lack of/ unavailability of electrical distribution system back up.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Auto Changeover system - On loss of power to LV sub A1 panel, ACB failed to take secondary supply system (SPS generator backup) ACB failed to take load on 3 separate attempts of testing	20	Catastrophic	Highly Likely	Red	Auto Changeover system - On loss of power to LV sub A1 panel, ACB failed to take secondary supply system (SPS generator backup) ACB failed to take load on 3 separate attempts of testing	10	Catastrophic	Unlikely	Amber	Switchgear/ infrastructure upgrades will mitigate risk.	Tolerate	None specified. Has document: No Adrian Griffin 09/04/2025 14:06	LVAP action plan include - Electrical team providing ongoing weekly checks BMS Alarms to shift pager is being investigated/feasibility to provide early warning of changeover failure Emergency SOP in place with all Electrical team/shift teams - manual switching of ACB – restoring secondary supply to high risk areas (risk in delay of time to attend minimum time of 5/10 minutes, maximum time of 40 minutes) potentially without power for this duration Mitigation on attendance timeline: lift support system is covered by uninterruptible power supplies (UPS systems) up to 60 minutes (can vary on loading will affect duration) Panelboard coverage - include life support areas, main theatres, pre-operation, post-operation, ITU, Home Office Essential Areas, Essential Public Heath Wales Labs Investigations on the ACB completed by a specialist electrical	Unable to test generators on-load (monthly test) as per HTM 06-01 requirement Has document: No Adrian Griffin 09/04/2025 14:10	N		Review date: 09/10/2025 Is reviewed: No Adrian Griffin 09/04/2025 14:17
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2023-2406	Both DSS4 Maternity HV substation double doors and LV switchroom single door	09/09/2023	Both DSS4 Maternity HV substation double doors and LV switchroom single door are made from slatted wooden doors and rotten, damaged and not secure for the location of the HV/LV substations.	Wooden doors and rotten, damaged and not secure.	The condition of the doors will impact upon the security of the switch rooms leading potentially to unauthorised access.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Both DSS4 Maternity HV substation double doors and LV switchroom single door are made from slatted wooden doors and rotten, damaged and not secure for the location of the HV/LV substations.	20	Catastrophic	Highly Likely	Red	Both DSS4 Maternity HV substation double doors and LV switchroom single door are made from slatted wooden doors and rotten, damaged and not secure for the location of the HV/LV substations.	5	Catastrophic	Highly Unlikely	Green	The replacement of both sets of doors to metal/steel type with securefixing and locks, with CLIQ key system, will prevent unauthorised access.	Tolerate	Monitor condition until planned replacement Has document: No Adrian Griffin 10/04/2025 14:53	Due to the condition and no solid fixing availability and loose fitting doors plus the possibility of barring open the doors allowing access into the HV/LV rooms No assurances. No issues to date but high possibilty Has document: No Adrian Griffin 10/04/2025 14:56	Due to the condition no solid fixing, loose fitting doors, plus possible barring open the doors into the HV/LV rooms No assurances. No issues to date but high possibilty Has document: No Adrian Griffin 10/04/2025 14:59	N		Review date: 03/11/2025 Is reviewed: No Adrian Griffin 04/08/2025 13:47 Review date: 30/09/2025 Is reviewed: Yes Adrian Griffin 10/04/2025 15:04
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2023-2408	Safe Access Cold Water Storage Tank (CWST) (BSB)	14/10/2023	Safe Access to the CWST (BSB) is difficult.	No ladder or any safe means of access to carry out statutory tank inspections and testing.	Serious risk of fall from height and injury to the person.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Safe Access to the CWST (BSB) is difficult with no ladder or any safe means of access to carry out statutory tank inspections and testing. Potential, serious risk of fall from height and injury to person.	20	Catastrophic	Highly Likely	Red	Safe Access to the CWST (BSB) is difficult with no ladder or any safe means of access to carry out statutory tank inspections and testing. Potential, serious risk of fall from height and injury to person.	5	Catastrophic	Highly Unlikely	Green	By means of a design and installation, of a permanent, secure and safe means of access.	Tolerate	The CWST has been inspected and a further visit required to see what temporary solution can be put in place. Has document: No Adrian Griffin 15/04/2025 14:49	Monthly , quarterly and annual thorough cleaning of the CWST is required and some safe access as a temporary measure utilised until permanent access can be installed. Has document: No Adrian Griffin 15/04/2025 14:53	Both contractors and estates labour require access. Has document: No Adrian Griffin 15/04/2025 14:56	N		Review date: 29/11/2025 Is reviewed: No Adrian Griffin 04/08/2025 13:15 Review date: 30/08/2025 Is reviewed: Yes Adrian Griffin 15/04/2025 15:03
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2023-2405	2 Unservicable Boilers (from 6)	04/08/2023	2 Boilers unservicable out of 6	Leaking flue causing damage to the printed circuit boards related to boiler control.	Possibility of losing heating or hot water, affecting clinics and patient care (leaking flue affected PCB's)	Team Meeting Board	20	Catastrophic	Highly Likely	Red	The loss of these boilers will affect clinics and overall patient care.	20	Catastrophic	Highly Likely	Red	The loss of these boilers will affect clinics and overall patient care.	5	Catastrophic	Highly Unlikely	Green	Bringing these boilers back on stream will provide the necessary infrastructure to ensure that clinics can continue to operate safely and to ensure the continuity of patient care.	Tolerate	Leak diverted / temporary fix until Flu repair has been carried Has document: No Adrian Griffin 05/06/2025 14:03	None specified. Has document: No Adrian Griffin 05/06/2025 14:03	None specified. Has document: No Adrian Griffin 05/06/2025 14:04	N		Review date: 05/09/2025 Is reviewed: No Adrian Griffin 05/06/2025 13:21
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2025-2610	Roofing Sheets Rusted Through	05/06/2025	Roofing sheets rusted through (at high level) A Block Link	Corrosion - possible lack of maintenance due to the inaccessibility, due to the height and lack safety infrastructure for safe working.	Ingress of water causing flooding to the floors/ office space below.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Damage caused by the ingress of water, more concerning would be the detachment of the roofing sheets from a position of height.	20	Catastrophic	Highly Likely	Red	Damage caused by the ingress of water, more concerning would be the detachment of the roofing sheets from a position of height.	5	Catastrophic	Highly Unlikely	Green	The renewal of the roof/ extensive repairs to the roof will remove the risk.	Tolerate	Contractor attended site to look at temporary repair, before further damage can be caused by inclement weather (Flooding below and roof sheet deterioration) Has document: No Adrian Griffin 05/06/2025 14:07	None specified. Has document: No Adrian Griffin 05/06/2025 14:09	None specified. Has document: No Adrian Griffin 05/06/2025 14:10	N		Review date: 05/09/2025 Is reviewed: No Adrian Griffin 05/06/2025 14:17
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2025-2601	UHW, currently as no Chlorine Dioxide dosing into the cold water system.	24/06/2025	No Chlorine Dioxide dosing into the cold water system.	Not previously installed into the cold water system.	Lack of Chlorine Dioxide dosing (which would provide additional assurance).	Team Meeting Board	20	Catastrophic	Highly Likely	Red	No Chlorine Dioxide dosing into the cold water system.	20	Catastrophic	Highly Likely	Red	No Chlorine Dioxide dosing into the cold water system.	5	Catastrophic	Highly Unlikely	Green	To upgrade the chemical control system to help combat and eradicate potential legionella bacterial growth and risk to patients and invest and review new advanced technology; E.G. a new system cold Copper-Silver Ionisation which is proven or Chloric acid system.	Tolerate	Maintenance program in place to strip and clean TMVs and filters. Ongoing routine water sampling and remedial works to disinfect the outlet. Temperature control on hot water system distribution. Has document: No Adrian Griffin 16/07/2025 14:57	Reliance of clinical staff carrying out manual flushing as per the C&V water safety plan and procedures. Has document: No Adrian Griffin 16/07/2025 14:58	Without dosing into the cold water system unable to provide assurance on the cold water system. Has document: No Adrian Griffin 16/07/2025 14:59	N		Review date: 15/10/2025 Is reviewed: No Adrian Griffin 16/07/2025 15:10
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2022-2304	General Issues With I.T. Ports - BEMS	14/12/2022	Issues with BEMS related I.T. Ports	The ports become locked preventing system communications over the network.	Affecting plant - primarily its control functions.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	The ports become locked and no system communications over the network and affects plant and control functions.	20	Catastrophic	Highly Likely	Red	The ports become locked and no system communications over the network and affects plant and control functions.	5	Catastrophic	Highly Unlikely	Green	Interaction, co-operation by all parties plus investment would improve/ negate the current position by improving BEMS p[erformance.	Tolerate	Contact IT department to reset the I.T. port. Has document: No Adrian Griffin 06/06/2025 13:28	Can operate valves, pumps and vents manually. Has document: No Adrian Griffin 06/06/2025 13:30	Not ideal and adds additional pressures to the already stretched estates team. Has document: No Adrian Griffin 06/06/2025 13:31	N		Review date: 05/09/2025 Is reviewed: No Adrian Griffin 06/06/2025 13:39
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2023-2602	Issues to control Legionella bacteria.	23/06/2025	Ongoing issues to control Legionella bacteria.	Modifications to clinical areas has made the system to control difficult.	Legionella positive water sample results are of concern and require consideration and action.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Due to the ongoing issues to control Legionella bacteria positive water sample results, the requirement for a different system that will provide adequate control and eradication of legionella risk in the water system.	20	Catastrophic	Highly Likely	Red	Due to the ongoing issues to control Legionella bacteria positive water sample results, the requirement for a different system that will provide adequate control and eradication of legionella risk in the water system.	8	Minor	Highly Likely	Amber	To upgrade the chemical control system to help combat and eradicate potential legionella bacterial growth and risk to patients and invest and review new advanced technology; E.G. a new system cold Copper-Silver Ionisation which is proven or Chloric acid system	Tolerate	Currently estates have Chlorine Dioxide dosing into the cold water system and manual flushing by estates and clinical staff. Maintenance program in place to strip and clean TMVs and filters. Ongoing routine water sampling and remedial works to disinfect the outlet. Temperature control on hot water system distribution. Has document: No Adrian Griffin 16/07/2025 14:32	Reasonable assurance with the work carried out to fight the legionella bacteria. Has document: No Adrian Griffin 16/07/2025 14:32	Due to the age of the system, modifications to clinical areas has made the system to control difficult Has document: No Adrian Griffin 16/07/2025 14:33	Y		Review date: 15/10/2025 Is reviewed: No Adrian Griffin 16/07/2025 14:36
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2025-2603	MRC plant room condition.	12/06/2025	MRC plant failure. Plant failure would significantly impact the services provided.	Aged plant and equipment/ general condition.	High risk of failure. Whole plant room needs total full refurbishment of plant infrastructure. Heating calorifier and access limited. Single calorifier unlagged and uneconomical. Condense Receiver has a big split in the tank surrounded with asbestos, high cost for removal. Hot water cylinder original copper cylinder beyond working life and ready to fail. Condensate pumps corroded and poor condition. Electrics containment and switches corroded. Old BMS controls. Poor circulation on heating system. Disruption to dept. services users (IPC -Housekeeping Department-Medical records Staff). High financial cost for the whole of the plant infrastructure. Rusted corroded failed/pipework valves – Needs replacing	Team Meeting Board	16	Major	Highly Likely	Red	High risk of failure. Whole plant room needs total full refurbishment of plant infrastructure. Heating calorifier and access limited. Single calorifier unlagged and uneconomical. Condense Receiver has a big split in the tank surrounded with asbestos, high cost for removal. Hot water cylinder original copper cylinder beyond working life and ready to fail. Condensate pumps corroded and poor condition. Electrics containment and switches corroded. Old BMS controls. Poor circulation on heating system. Disruption to dept. services users (IPC -Housekeeping Department-Medical records Staff). High financial cost for the whole of the plant infrastructure. Rusted corroded failed/pipework valves – Needs replacing	20	Catastrophic	Highly Likely	Red	High risk of failure. Whole plant room needs total full refurbishment of plant infrastructure. Heating calorifier and access limited. Single calorifier unlagged and uneconomical. Condense Receiver has a big split in the tank surrounded with asbestos, high cost for removal. Hot water cylinder original copper cylinder beyond working life and ready to fail. Condensate pumps corroded and poor condition. Electrics containment and switches corroded. Old BMS controls. Poor circulation on heating system. Disruption to dept. services users (IPC -Housekeeping Department-Medical records Staff). High financial cost for the whole of the plant infrastructure. Rusted corroded failed/pipework valves – Needs replacing	5	Catastrophic	Highly Unlikely	Green	Refurbisment of the plant room will protect against plant/ services failure.	Tolerate	Estatesr continue to monitor on a weekly basis and look to repair minor repairs when required. We have diverted the current leak from the calorifier. Has document: No Adrian Griffin 16/07/2025 13:48	Due to the size of the works required and financial risk cost, this needs to be passed for Capital intervention to replace whole plant infrastructure. This should be looked at before and review the winter season. Has document: No Adrian Griffin 16/07/2025 13:49	High risk of failure of large plant and to provide heating and hot water to the service users. Has document: No Adrian Griffin 16/07/2025 13:51	N		Review date: 15/10/2025 Is reviewed: No Adrian Griffin 16/07/2025 14:04
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2025-2604	Roof parapet wall not to regulation height.	01/05/2025	Roof Parapet wall not to regulation height (1.1M)	Parapet wall not to regulation height. Local Mansafe system inaccessible.	Suitable edge protection unavailable. Mansafe is not safely accessible in it's current state (to clip on lifeline, you would have to climb onto sloping roof to be able to clip on). As AC Units section cover place of safe access.	Team Meeting Board	20	Major	Almost Certain	Red	Possible fall from height.	20	Major	Almost Certain	Red	Possible fall from height.	4	Major	Highly Unlikely	Green	Possibly, bringing the parapet wall to regulation height would be impractible. Therefore, ensuring that the Mansafe system is easily accessible providing the required level of safety for working at height.	Tolerate	Restrict access. Has document: No Adrian Griffin 16/07/2025 11:07	None specified. Has document: No Adrian Griffin 16/07/2025 11:07	None specified. Has document: No Adrian Griffin 16/07/2025 11:08	N		Review date: 15/10/2025 Is reviewed: No Adrian Griffin 16/07/2025 11:29
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2025-2605	Roof Lifeline/Mansafe covered & obstructed	01/05/2025	Roof Lifeline/Mansafe covered & obstructed.	Persons are unable to clip onto the Mansafe line.	The lifeline is unusable in it's current state and as parts of the lifeline are under the AHU, it cannot be certified for use under LOLER.	Team Meeting Board	20	Major	Almost Certain	Red	Roof Lifeline/Mansafe covered & obstructed.	20	Major	Almost Certain	Red	Roof Lifeline/Mansafe covered & obstructed.	4	Major	Highly Unlikely	Green	If the Mansafe is redirected and free from obstruction. Subject to a satisfactory test and inspection. The Mansafe can then be returned to service to facilitate use by qualified personnel.	Tolerate	Restrict / No Access, lifeline cannot be used. Has document: No Adrian Griffin 16/07/2025 10:35	Access restricted. Has document: No Adrian Griffin 16/07/2025 10:38	None specified. Has document: No Adrian Griffin 16/07/2025 10:39	N		Review date: 15/10/2025 Is reviewed: No Adrian Griffin 16/07/2025 10:52

Capital Estates and Facilities	CEF - Estates	CEF - Estates/2025-2606	Overtime authorisation potentially not given - Team Leader	11/02/2025	Due to overtime authorisation not given, there will be occasions when there will be no qualified and competent Team Leader on site out of hours to respond to emergencies.	Budget constraints.	These emergencies consist of loss of electrical supply, fire alarm activation, loss of medical gases including oxygen, loss of mechanical services such as critical ventilation such as theatres, heating hot water and steam which is used for sterilisation, lift entrapments, significant health and safety concern relating to the patient experience or staff and visitor safety.	Team Meeting Board	20	Major	Almost Certain	Red	Due to overtime authorisation not given, there will be occasions when there will be no qualified and competent Team Leader on site out of hours to respond to emergencies. These emergencies consist of loss of electrical supply, fire alarm activation, loss of medical gases including oxygen), loss of mechanical services such as critical ventilation such as theatres, heating hot water and steam which is used for sterilisation, lift entrapments, significant health and safety concern relating to the patient experience or staff and visitor safety.	20	Major	Almost Certain	Red	Due to overtime authorisation not given, there will be occasions when there will be no qualified and competent Team Leader on site out of hours to respond to emergencies. These emergencies consist of loss of electrical supply, fire alarm activation, loss of medical gases including oxygen), loss of mechanical services such as critical ventilation such as theatres, heating hot water and steam which is used for sterilisation, lift entrapments, significant health and safety concern relating to the patient experience or staff and visitor safety.	4	Major	Highly Unlikely	Green	Required staffing levels will remove the risk of service failure.	Tolerate	Escalate to Senior Management Team & SMOC, Has document: No Adrian Griffin 16/07/2025 09:37	None available Has document: No Adrian Griffin 16/07/2025 09:38	None, due to levels of constraints around overtime payments, time and travelling to site. Has document: No Adrian Griffin 16/07/2025 09:40	N		Review date: 15/10/2025 Is reviewed: No Adrian Griffin 16/07/2025 09:57
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2025-2607	Overtime authorisation potentially not given - Mechanical	11/02/2025	Due to authorisation not given, there will be occasions when there will be no qualified and competent Mechanical Engineer on site out of hours to respond to emergencies.	Budget constraints.	These emergencies consist of loss of medical gases including oxygen, loss of mechanical services such as critical ventilation such as theatres, heating hot water and steam (sterilisation), lift entrapments, significant health and safety concern relating to patient experience or staff and visitor safety.	Team Meeting Board	20	Major	Almost Certain	Red	Due to overtime authorisation not given, there will be occasions when there will be no qualified and competent Mechanical Engineer on site out of hours to respond to emergencies. These emergencies consist of the loss of medical gases including oxygen, loss of mechanical services such as critical ventilation such as theatres, heating hot water and steam which is used for sterilisation, lift entrapments, significant health and safety concern relating to the patient experience or staff and visitor safety. "	20	Major	Almost Certain	Red	Due to overtime authorisation not given, there will be occasions when there will be no qualified and competent Mechanical Engineer on site out of hours to respond to emergencies. These emergencies consist of the loss of medical gases including oxygen, loss of mechanical services such as critical ventilation such as theatres, heating hot water and steam which is used for sterilisation, lift entrapments, significant health and safety concern relating to the patient experience or staff and visitor safety. "	4	Major	Highly Unlikely	Green	Required staffing levels will remove the risk of service failure.	Tolerate	Escalation to Senior Management team & SMOC. Has document: No Adrian Griffin 08/07/2025 14:20	None available. Has document: No Adrian Griffin 08/07/2025 14:20	None, due to levels of constraints around overtime payments, time and travelling to site. Has document: No Adrian Griffin 08/07/2025 14:21	N		Review date: 07/10/2025 Is reviewed: No Adrian Griffin 08/07/2025 14:47
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2025-2608	Overtime authorisation potentially not given - Electrical	11/02/2025	Due to overtime authorisation not given, there will be occasions when there will be no qualified and competent Electrical Engineer on site out of hours to respond to emergencies.	Budget constraints.	These emergencies consist of fire alarm activation, loss of electrical power, lift entrapments, significant health and safety concern/s relating to the patient experience or staff and visitor safety.	Team Meeting Board	20	Major	Almost Certain	Red	Due to overtime authorisation not given, there will be occasions when there will be not qualified and competent Electrical Engineer on site out of hours to respond to emergencies. These emergencies consist of fire alarm activation, loss of electrical power, lift entrapments, significant health and safety concern relating to the patient experience or staff and visitor safety.	20	Major	Almost Certain	Red	Due to overtime authorisation not given, there will be occasions when there will be not qualified and competent Electrical Engineer on site out of hours to respond to emergencies. These emergencies consist of fire alarm activation, loss of electrical power, lift entrapments, significant health and safety concern relating to the patient experience or staff and visitor safety.	4	Major	Highly Unlikely	Green	Required staffing levels will remove the risk of service failure.	Tolerate	Escalation to Senior High Voltage Engineer, Senior Management Team & SMOC. Has document: No Adrian Griffin 07/07/2025 15:17	None available. Has document: No Adrian Griffin 07/07/2025 15:18	None, due to levels of constraints around time and travelling to site. Has document: No Adrian Griffin 07/07/2025 15:18	N		Review date: 06/10/2025 Is reviewed: No Adrian Griffin 07/07/2025 15:23
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2025-2609	Working at Height lack of edge protection	16/01/2025	Edge protection to the east and West elevations of the roof only.	Lack of edge protection/ mansafe system.	Potential for a fall from height. Limited access to the roof area.	Team Meeting Board	20	Major	Almost Certain	Red	The lack of edge protection/ mansafe system in the event of needing to access the roof.	20	Major	Almost Certain	Red	The lack of edge protection/ mansafe system in the event of needing to access the roof.	4	Major	Highly Unlikely	Green	The installation of edge protection/ mansafe system will signifficantly decrease the risk if access is required to this currently restyricted area of operation.	Tolerate	Access restricted. Has document: No Adrian Griffin 07/07/2025 14:25	Restrict access to the gutter walkway only. Has document: No Adrian Griffin 07/07/2025 14:26	Personel not adhering to the instruction to utilise the access gutter walkway (access gutter not an ideal solution). Has document: No Adrian Griffin 07/07/2025 14:38	N		Review date: 06/10/2025 Is reviewed: No Adrian Griffin 07/07/2025 14:55
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2024-2501	Cold water supply to theatres (CAVOC, Spinal)	02/12/2024	54MM pipework is leaking, possibly across multiple locations. The locations of the leaks are masked by asbestos containg materials e.g. pipe lagging.	The pipework is pin holed across a distance20 mts.	The removal of the pipe lagging would constitute a licensable removal. The removal of the lagging could possibly expediate the failing copndition of the 54mm pipework.	Team Meeting Board	20	Major	Almost Certain	Red	The pipework supplies the cold water to the CAVOC and spinal theatres.	20	Major	Almost Certain	Red	The pipework supplies the cold water to the CAVOC and spinal theatres.	4	Major	Highly Unlikely	Green	A repair will remove the potential for any failure of the corrodedpipe work.	Tolerate	Temporary watewr supply diversion initiated. Has document: No Adrian Griffin 07/07/2025 14:01	Temporary bypass to keep the areas previously identified as operational. Has document: No Adrian Griffin 07/07/2025 14:02	The bypass is a short term solution. Has document: No Adrian Griffin 07/07/2025 14:02	N		Review date: 06/10/2025 Is reviewed: No Adrian Griffin 07/07/2025 14:07
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2024-2503	Leaking Flue - CRI Main plant room	16/04/2024	Leaking flue into CRI Plant Room.	The Flue is leaking in CRI main plantroom.Early indications are its leaking through the double skinned flue. The leak is coming back onto the boilers and causing considerable damage and corrosion to the boilers resulting in expensive repairs and a safety concern. We are awaiting more information on what the exact cause is as it appears to be condensation from the flue.	The risk of major failure is likely if the boilers fail as this offers large parts of CRI, heating and hot water.	Team Meeting Board	20	Major	Almost Certain	Red	The leak is coming back onto the boilers and causing considerable damage and corrosion to the boilers resulting in expensive repairs and a safety concern.	20	Major	Almost Certain	Red	The leak is coming back onto the boilers and causing considerable damage and corrosion to the boilers resulting in expensive repairs and a safety concern.	4	Major	Highly Unlikely	Green	Replace boilers and flues.	Tolerate	We have tried to minimise the damage to the boilers by putting a temporary system in place to catch the water. The x2 back up boilers are currently awaiting repairs with Equans, but the boilers have considerable damage. The long term solution is a flue replacement and boilers, but obviously in the short term this is not a realistic option. Has document: No Adrian Griffin 03/07/2025 14:47	None specified. Has document: No Adrian Griffin 03/07/2025 14:48		N		Review date: 03/10/2025 Is reviewed: No Adrian Griffin 03/07/2025 14:55
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2023-2403	VIE underground piped oxygen - From estates.	18/10/2023	VIE piped oxygen runs underground. No ducting and large tree growing above the oxygen pipe run.	Environmental issue, tree roots encroaching on oxygen pipe run. Ducting should have been installed along the pipe run to ensure the protection and containment of the oxygen pipe along its length.	Potential loss of oxygen supply caused by environmental damage.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	This concern has also be raised by the MGPS Authorising Engineer as a potential point of failure.	20	Catastrophic	Highly Likely	Red	This concern has also be raised by the MGPS Authorising Engineer as a potential point of failure.	5	Catastrophic	Highly Unlikely	Green	Replacement and redirection of the main oxygen pipework run into the hospital would provide the necessary assurance for the continuity of supply.	Tolerate	C&V UHB an have emergency manifold system for an emergency scenario, but not for longivity to maintain oxygen demand for hospital. Has document: No Adrian Griffin 10/06/2025 10:36	Planned improvement works to site oxygen from the second site VIE. The long term project and the estates VIE will form part of the overall improvement plan. Has document: No Adrian Griffin 10/06/2025 10:37	Unsure of general condition of buried oxygen pipework. Has document: No Adrian Griffin 10/06/2025 10:39	N		Review date: 31/10/2025 Is reviewed: No Adrian Griffin 10/06/2025 12:54
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2023-2404	Satchwell Sigma BMS Control Cards	18/01/2023	Control cards are no longer supported.	The unavailability of control cards will potentially impact upon heating/ventilation/ LTHW/DHW and cooling in the following areas - UHW Operating theatres (plantroom 19), CHFW theatres, SSSU day theatres, ITU, NICU, Boiler House, Multiple Cardiff University labs including BIOVS facility (regulated by Home office, reportable when out of compliance) Known outstations failures have increased due to the start-up of heating session instigation across various location	Loss of service and patient care facilities.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	USED/second hand BMS cards have now been totally used-up, no further stock or availability in-place.	20	Catastrophic	Highly Likely	Red	USED/second hand BMS cards have now been totally used-up, no further stock or availability in-place.	5	Catastrophic	Highly Unlikely	Green	The upgrade of the BEMS infrastructure will remove the issue of the unavailability of spare printed circuit boards etc. for a number of years. Providing the necessary future proofing and performance of the BEMS.	Tolerate	Have now been limited to unknown second-hand option's (potentially unavailability) Has document: No Adrian Griffin 10/06/2025 10:02	None specified. Has document: No Adrian Griffin 10/06/2025 10:03	Minimal Upgrades have taken part, recent issues with IM&T ports closing down, firewall rules not allowing communication, single points of failure BMS computer, no IT direct support. Has document: No Adrian Griffin 10/06/2025 10:04	N		Review date: 09/09/2025 Is reviewed: No Adrian Griffin 10/06/2025 10:17
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2022-2302	Community Barry Drainage issue	14/12/2022	Drainsage problems unable to flow backing up.	Various - patients do flush materials e.g. paper hand towels down toilets.	External contractor call to jet the sewerage/ drainage lines, at considerable cost.	Team Meeting Board	20	Major	Almost Certain	Red	Toilets/ waste water outlets are removed from operation due to downstream blockages. Operatio, resouce and cost issues ensuing.	20	Major	Almost Certain	Red	Toilets/ waste water outlets are removed from operation due to downstream blockages. Operatio, resouce and cost issues ensuing.	4	Major	Highly Unlikely	Green	Improved access to internal inspection chambers. Re-benching.	Tolerate	The drains are checked on a weekly basis. Camera survey carried out, contractor has reported the underlying problem is the drains may need re-benching. Has document: No Adrian Griffin 06/06/2025 14:35	Meeting with TSF flooring contractor at Barry Hospitsl to see if a solution can be devised. Has document: No Adrian Griffin 06/06/2025 14:35	Improper materials being flushed causing additional issues. Has document: No Adrian Griffin 06/06/2025 14:36	N		Review date: 06/09/2025 Is reviewed: No Adrian Griffin 06/06/2025 14:37
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2022-2303	UHW Mains water services risk of failure	14/12/2022	Failure of mains water services.	Aged infrastructure.	Supply failure. Preventing mains water supply.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Each year we experience pipe failures and requires excavation works to repair.	20	Catastrophic	Highly Likely	Red	Each year we experience pipe failures and requires excavation works to repair.	5	Catastrophic	Highly Unlikely	Green	Replacement of the water supply infrastructure would mitigate the risk of infrastructure failure.	Tolerate	Most repairs can be completed within 48 hours depending on location of the leak and a water bowser can be hired to provide water supply. Has document: No Adrian Griffin 06/06/2025 14:01	Currently only short duration with water turned off for repair to minimise disruption to services and areas affected. Has document: No Adrian Griffin 06/06/2025 14:02	None specified. Has document: No Adrian Griffin 06/06/2025 14:02	N		Review date: 05/09/2025 Is reviewed: No Adrian Griffin 06/06/2025 14:08
Capital Estates and Facilities	CEF - Estates	CEF - Estates/2019-2001	Theatre Block UHL AHU Component Failure	22/05/2019	Component failure, leading to the inoperability of critical equipment.	Star delta control parts obsolete.	Procedures/ operations being cancelled, delayed or moved.	Team Meeting Board	20	Major	Almost Certain	Red	Component failure in star delta control. Obsolete parts in all AHUs	20	Major	Almost Certain	Red	Component failure in star delta control. Obsolete parts in all AHUs	4	Major	Highly Unlikely	Green	Plans in place to fit direct drives to all systems under the refit scheme	Tolerate	Equipment is currently being maintained ro a reasonable standard. Plans in place to fit direct drives to all systems under the refit scheme. Has document: No Adrian Griffin 06/06/2025 11:49	Some parts are maintained in stock at the curent time. Has document: No Adrian Griffin 06/06/2025 11:54	Some parts in stock although becoming depleted. Has document: No Adrian Griffin 06/06/2025 11:50	N		Review date: 05/09/2025 Is reviewed: No Adrian Griffin 06/06/2025 12:00
Capital Estates and Facilities	CEF - Mechanical	CEF - Mechanical/2021-2207	UHW & UHL Medical Gas Pressure Reducing Sets.	01/01/2021	Potential to fail - Medical Gas Pressure reducing sets	Are out of the manufacturers recommended operational service date periods.	Equipment Failure leading to Loss of Service and Interruption of supply impacting on patients	Team Meeting Board	25	Catastrophic	Almost Certain	Red	UHW & UHL Medical Gas Pressure reducing sets are out of manufacturers recommended operational service date. Equipment Failure leading to Loss of Service and Interruption of supply impacting on patients	25	Catastrophic	Almost Certain	Red	UHW & UHL Medical Gas Pressure reducing sets are out of manufacturers recommended operational service date. Equipment Failure leading to Loss of Service and Interruption of supply impacting on patients	5	Catastrophic	Highly Unlikely	Green	UHL set has been replaced, the second set is due for completion under current upgrade scheme and is due for completion March 2023. There are approximately 15 sets at UHW. Funding has been approved for 6 sets which are due to be completed this financial year. Funding for the remaining sets is being sourced.	Tolerate	Regular maintenance being carried out Has document: No Adrian Griffin 07/08/2025 12:39	UHL set has been replaced, the second set is due for completion under current upgrade scheme and is due for completion March 2023. There are approximately 15 sets at UHW. Funding has been approved for 6 sets which are due to be completed this financial year. Funding for the remaining sets is being sourced. Has document: No Adrian Griffin 07/08/2025 12:40	Not compliant with HTM Has document: No Adrian Griffin 07/08/2025 12:41	Y		Review date: 06/11/2025 Is reviewed: No Adrian Griffin 07/08/2025 12:43
Capital Estates and Facilities	CEF - Mechanical	CEF - Mechanical/2023-2404	UHW Maternity suites	02/10/2023	There is a risk that the Ventilation AHU serving maternity suites have major issues.	Potentially original design and installation issue. Non compliance to the HTM.	AHU failure leading to loss of service to the maternity suites.	Team Meeting Board	20	Major	Almost Certain	Red	Ventilation AHU serving Maternity delivery suites does not comply to HTM's. There are major issues with it's Air Handling Unit, replacement recommended.	20	Major	Almost Certain	Red	Ventilation AHU serving Maternity delivery suites does not comply to HTM's. There are major issues with it's Air Handling Unit, replacement recommended.	4	Major	Highly Unlikely	Green	The replacement of the AHU will ensure operational stability and compliance to the HTM.	Tolerate	Regular maintenance being carried out to maintain the systems as is. Has document: No Adrian Griffin 12/08/2025 09:13	System is subject to statutory testing and inspection in line with legislation and HTM Has document: No Adrian Griffin 12/08/2025 09:14	Replacement of AHU required Has document: No Adrian Griffin 12/08/2025 09:15	Y		Review date: 11/11/2025 Is reviewed: No Adrian Griffin 12/08/2025 09:18
Capital Estates and Facilities	CEF - Mechanical	CEF - Mechanical/2023-2405	UHW Main Recovery	02/10/2023	There is a risk that the ventilation verification of the critical systems at UHW main recovery has identified a non compliant plant.	Potentially Initial incorrect design and installation. Changes to the HTM.	Potential AHU failure leading to the loss of service.	Team Meeting Board	20	Catastrophic	Highly Likely	Red	Ventilation verification of critical systems has identified a non compliant plant and airflow serving main recovery at UHW	20	Catastrophic	Highly Likely	Red	Ventilation verification of critical systems has identified a non compliant plant and airflow serving main recovery at UHW	5	Catastrophic	Highly Unlikely	Green	Replacement of AHU to ensure compliance to the HTM ensuring correct air flow.	Tolerate	Regular maintenance being carried out. Has document: No Adrian Griffin 08/08/2025 10:03	System is subject to statutory testing and inspection in line with legislation and HTM as far as possible. Has document: No Adrian Griffin 08/08/2025 10:04	Overall the system needs replacing. Has document: No Adrian Griffin 08/08/2025 10:05	Y		Review date: 07/11/2025 Is reviewed: No Adrian Griffin 08/08/2025 10:11

Capital Estates and Facilities	CEF - Mechanical	CEF - Mechanical/2021-2205	UHW ITU C3 Link Non Compliance	01/06/2021	There is a risk that the Ventilation verification of UHW Cardiac ITU C3 Link is Non Compliant.	This is caused by non compliance to the Hospital Technical Memorandum (HTM).	Which would lead to the HTM not being adhered to.	Team Meeting Board	20	Catastrophic	High/y Likely	Red	System has never complied with HTM'S	20	Catastrophic	High/y Likely	Red	System has never complied with HTM'S	5	Catastrophic	High/y Unlikely	Green	Refurbishment of plant and equipment to raise the standard to that of ensuring compliance to the HTM.	Tolerate	Regular maintenance being carried out Has document: No Adrian Griffin 06/08/2025 14:22	None specified. Has document: No Adrian Griffin 06/08/2025 14:24	System isn't suitable and correct maintenance is restricted. Control measures are not sufficient to reduce the risks significantly Has document: No Adrian Griffin 06/08/2025 14:25	Y		Review date: 05/11/2025 Is reviewed: No Adrian Griffin 06/08/2025 14:28
Capital Estates and Facilities	CEF - Mechanical	CEF - Mechanical/2021-2204	UHW ITU B3N Non Compliance	01/06/2021	There is a risk that the Ventilation verification of UHW ITU B3N is Non Compliant.	This is caused by non compliance to the Hospital Technical Memorandum (HTM).	Which would lead to the HTM not being adhered to.	Team Meeting Board	20	Catastrophic	High/y Likely	Red	System has never complied with HTM'S	20	Catastrophic	High/y Likely	Red	System has never complied with HTM'S	5	Catastrophic	High/y Unlikely	Green	Refurbishment of plant and equipment to raise the standard to that of ensuring compliance to the HTM.	Tolerate	Maintenance intermitent due to access issues AHU within ward. Has document: No Adrian Griffin 06/08/2025 11:59	None specified. Has document: No Adrian Griffin 06/08/2025 11:59	Maintenance intermitent due to access issues AHU within ward. Has document: No Adrian Griffin 06/08/2025 12:01	Y		Review date: 05/11/2025 Is reviewed: No Adrian Griffin 06/08/2025 12:04
Capital Estates and Facilities	CEF - Mechanical	CEF - Mechanical/2021-2202	UHW ITU A3N Non Compliance	01/06/2021	There is a risk that the Ventilation verification of UHW ITU A3N is Non Compliant.	This is caused by non compliance to the Hospital Technical Memorandum (HTM).	Which would lead to the HTM not being adhered to.	Team Meeting Board	20	Catastrophic	High/y Likely	Red	System has never complied with HTM'S	20	Catastrophic	High/y Likely	Red	System has never complied with HTM'S	5	Catastrophic	High/y Unlikely	Green	Refurbishment of plant and equipment to raise the standard to that of ensuring compliance to the HTM.	Tolerate	Restricted maintenance operations. Has document: No Adrian Griffin 06/08/2025 11:36	None specified. Has document: No Adrian Griffin 06/08/2025 11:37	System is not suitable and correct maintenance is restricted, control measures are not sufficient to reduce the risks significantly. Has document: No Adrian Griffin 06/08/2025 11:38	Y		Review date: 05/11/2025 Is reviewed: No Adrian Griffin 06/08/2025 11:44