CARDIFF AND VALE UNIVERSITY HEALTH BOARD

PUBLIC BOARD MEETING

Thursday 24 September 2026 - 9:30 am - Woodland House, Coed Y Bwl

To observe this meeting online, *please click here on the day of the meeting*

Start time: 09:30	**1**	**Welcome, Introductions & Apologies for absence:**	**Presenters**
	2	Declarations of Interest	Kirsty Williams
	3	Minutes of the Board meeting held 30.07.2026	Kirsty Williams
	4	Action Log – following meeting held on: 28.05.2026	Kirsty Williams
	5	Consent Agenda Business	Kirsty Williams
09:40	**6**		
09:40 15 mins	6.1	Patient Story - The loss with dementia is constant – Alex's Story	Jason Roberts
09:55 10 mins	6.2	Chair's Report & Chair's Action taken since last meeting	Kirsty Williams
10:05 15 mins	6.3	Chief Executive Officer Report *including SLT updates which can be found in the supporting documents folder on the Cardiff and Vale UHB website: 2026 - 2027 Public Board Meetings - Cardiff and Vale University Health Board*	Chris Bown
10:20 10 mins	6.4	Board Assurance Framework	Matt Phillips
10:30 25 mins	6.5	Chairs' reports from Committees of the Board: 1) Finance & Performance – 16.09.2026 2) Quality – 28.07.2026 3) Digital & Infrastructure – 04.08.2026 4) People & Culture – 08.09.2026 5) Charitable Funds – 15.09.2026	Matt Phillips Rhian Thomas Ceri Phillips Rhian Thomas Susan Lloyd-Selby Judi Rhys
10:55 20 mins	6.6	Strategic Planning, Commissioning and Partnership	Adam Roberts
11:15	6.7	**BREAK – 5 minutes**	

11:20 20 mins	6.8	Targeted Intervention	Adam Roberts
11:40 15 mins	6.9	Welsh Gender Service	David Fluck
11:55 75 mins	6.10	Integrated Performance Report: • Exec Summary • Quality & Safety • Digital & Health Intelligence • Public Health • Finance • People & Culture • Operational Performance	Jason Roberts David Thomas Claire Beynon Catherine Phillips Rachel Gidman Catherine Wood
13:10	6.11	**LUNCH – 30 minutes**	
13:40 20 mins	6.12	Theatres Together Programme	Catherine Wood
14:00 10 mins	6.13	Dental Contract Reform	Catherine Wood
14:10 15 mins	6.14	Oversight of Access and Waiting Times in Primary and Community Care	Catherine Wood
	7	**Item for Approval / Ratification**	
14:25 15 mins	7.1	Corporate Risk Register	Matt Phillips
14:40	**8**	**Consent Agenda**	
	8.1	Pharmaceutical Needs Assessment *The full assessment is located in the supporting documents folder on the Cardiff and Vale UHB website: 2026 - 2027 Public Board Meetings - Cardiff and Vale University Health Board*	TBC (CB?)
14:40	**9**	**Items for Noting and Information**	
10 mins	9.1	Winter Plan	Catherine Wood
0 mins	9.2	Reports from Advisory Groups and Joint Committees:	Matt Phillips

		1) Shared Services Partnership Committee 16.07.2026 2) Joint Commissioning Committee 21.07.2026 Available in the Supporting Documents folder on the Cardiff and Vale UHB website: 2026 - 2027 Public Board Meetings - Cardiff and Vale University Health Board	
0 mins	9.2	Committee and Advisory Group Minutes: 1) *Charitable Funds 16.06.2026* 2) *Quality 30.06.2026* 3) *People & Culture 21.07.2026* Available in the Supporting Documents folder on the Cardiff and Vale UHB website: 2026 - 2027 Public Board Meetings - Cardiff and Vale University Health Board	Matt Phillips
14:50	**10**		
		Private Board Meeting Items: • *Minutes of the previous Private Board Meeting* • *Haemodialysis*	
14:50	**11**	**Any Other Business**	
	11.1	Review of the meeting:	Kirsty Williams
	11.2	**Time and date of the next Board meeting:** **26 November 2026**	

Declaration before moving into private session: *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
Microsoft Teams
30.07.2026 –

Chair:		
Kirsty Williams	KW	Chair of the Cardiff and Vale University Health Board
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
Emma Cooke	EC	Executive Director of AHPs, Health Science & Community Development
Lauranne Cullen	LC	Llais Representative
Clive Curtis	CC	Independent Member - Community
David Edwards	DE	Independent Member – ICT
David Fluck	DF	Executive Medical Director
Rachel Gidman	RG	Executive Director of People & Culture
Michaela John	MJ	Head of Programme - Genomics Partnership Wales
Victoria Le Grys	VLG	Deputy Director of Strategic Planning & Partnerships
Susan Lloyd Selby	SL	Independent Member – Local Authority
Lorna McCourt	LMc	Independent Member – Trade Union
Catherine Phillips	CP	Executive Director of Finance
Ceri Phillips	CPVC	University Health Board Vice Chair
Matt Phillips	MP	Director of Corporate Governance
Suzanne Rankin	SR	Chief Executive Officer
Judi Rhys	JRH	Independent Member – Third Sector
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
Rachna Upadhya	RU	Independent Member
Observers:		
Maddy Brown	MB	Management Graduate Trainee
Jac Mortimer	JM	Management Graduate Trainee
Kellen Wardrop	KW	Management Graduate Trainee
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Adam Roberts	AR	Executive Director of Strategy, Planning & Partnerships

To view a recording of this meeting, please click here – **PART ONE** or **PART TWO**
Each item can be viewed separately if preferred.

Ref	Agenda Item	
UHB 26/07/1	**Welcome, Introductions & Apologies for Absence** Kirsty Williams (KW), The Chair of Cardiff and Vale University Health Board (The Health Board) welcomed everybody to the meeting in English and Welsh. Apologies for absence were noted.	
UHB 26/07/2	**Declarations of Interest** No declarations of interest were raised.	
UHB 26/07/3	**Minutes of the Board Meeting held 28.05.2026, 23.06.2026 and the Annual General Meeting on 14.07.2026 – click to view** The minutes of the Board meetings held 28.05.2026, 23.06.2026 and the Annual General Meeting on 14.07.2026 were received. **The Board resolved that:**	

	a) The minutes of the Board meetings 28.05.2026, 23.06.2026 and the Annual General Meeting on 14.07.2026 were approved as a true and accurate record of the meeting.	
UHB 26/07/4	**Actions – Following Meeting held 28.05.2026 – click to view** Actions from the previous meeting were received. **The Board resolved that:** a) The Actions following the meeting held 28.05.2026 were noted.	
UHB 26/07/5	**Consent Agenda – click to view** KW advised the Board that the consent agenda items had received detailed scrutiny/review at another forum (e.g. a Committee of the Board) had been added to that consent agenda to negate the need for duplication of scrutiny. She asked if anybody wanted to highlight anything from that agenda to which no responses were received. **The Board resolved that:** a) The consent agenda items were noted, and formal approval of items would be noted.	
UHB 26/07/6.1	**Patient Story – "I was afraid to go out" - Stephen's Story – click to view** The Patient Story was received (click to view) The Board received a patient story presented by Dr Michael Perry, Consultant Clinical Scientist and Chair of the Wales C. difficile Working Group, regarding the experience of a patient who contracted C. difficile infection following hospital treatment. Dr Perry advised that rates of C. difficile infection had increased across Wales in recent years and remained a significant cause of morbidity. He explained that whilst large-scale outbreaks were now less common than in previous decades, patients continued to experience severe illness, with some suffering long-term physical, psychological and social impacts following infection. The patient story highlighted the significant effect that recurrent C. difficile infection could have on both patients and their families. Dr Perry emphasised the importance of raising awareness of C. difficile infection, including the risks associated with antibiotic use and the long-term consequences for patients. He noted that many patients continued to experience bowel symptoms after treatment and that access to specialist treatments, such as faecal microbiota transplantation, remained an area of ongoing development. Claire Beynon (CB), Executive Director of Public Health highlighted the role of communication and awareness and sought further information regarding the importance of hand hygiene in preventing C. difficile infection. Judi Rhys (JRH), Independent Member Third Sector commented on the importance of preventing infections and questioned why the epidemiology of C. difficile had changed, noting the shift from large outbreaks caused by a single strain to the current pattern of smaller outbreaks involving multiple strains. Susan Lloyd-Selby (SLS), Independent Member Local Authority, asked whether sufficient support and education were available within primary care to enable healthcare professionals to recognise and appropriately manage patients with C. difficile infection, particularly following surgery.	

	In response, Dr Perry advised that hand washing with soap and water remained essential in preventing C. difficile transmission, noting that alcohol hand gels were ineffective against C. difficile spores. He highlighted the need for greater awareness amongst healthcare professionals and the public regarding appropriate hand hygiene practices. He noted, however, that transmission still occurred and that whole genome sequencing was being used across Wales to better understand patterns of infection and support prevention efforts. He also advised that increasing numbers of infections were now being identified in community settings and that further work was underway to understand the changing epidemiology of the disease. KW thanked Dr Perry for presenting the patient story and noted that further information regarding the organisation's response to the national C. difficile improvement work would be highlighted later in the Integrated Performance Report. **The Board resolved that:** a) The Patient Story was noted.	
UHB 26/07/6.2	**Chairs Report – click to view** KW advised that she would take the report as read but highlighted two significant developments for the organisation. Firstly, she reported the launch of the Health Board's Clinical Services Plan (CSP), describing it as an important organisational milestone. She thanked staff for the significant work undertaken to develop the plan and noted the extensive co-production that had taken place with clinicians, patients, communities and stakeholder groups. KW stated that she looked forward to seeing the ambitions set out within the plan translated into service delivery and improvements for patients. Secondly, KW highlighted the recent opening of the new Theatre Recovery Suite at University Hospital of Wales. She advised that the development formed an important part of the organisation's Theatre Improvement Plan and noted that staff had reported the new facilities would support them in delivering high-quality patient care and would provide an improved working environment. **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 26/07/6.3	**Chief Executive Officer report – click to view** Suzanne Rankin (SR), Chief Executive Officer advised that her report provided assurance that work continued across the organisation's strategic objectives and that progress was being made in delivering the Health Board's strategy. She emphasised that the Executive Team remained fully committed to delivering agreed priorities and programmes of work throughout the forthcoming leadership transition period and expressed confidence that Board members could continue to rely on the Executive Team's collaboration, focus and commitment. Reflecting on her final Board meeting as Chief Executive, she thanked members for the Chair's earlier remarks and reflected on her time with the organisation. She stated that she believed the Health Board was in a stronger position than when she joined, whilst acknowledging that significant challenges and opportunities remained. SR advised that the plans and approaches currently in place were the right ones to support the organisation's future development. She encouraged the Board to maintain its focus on	

	delivering integrated healthcare, describing this as essential to achieving organisational resilience, sustainability and improved access to high-quality care for the population of Cardiff and the Vale of Glamorgan, as well as patients accessing specialist services from across Wales. She further emphasised the importance of continuing to focus on what mattered most to patients, citizens and communities whilst also giving equal priority to supporting staff, recognising their critical role in delivering services. SR thanked Board members and Executive colleagues for their support, challenge and collaboration during her tenure and expressed her confidence in the organisation's future leadership and direction. KW thanked SR for her reflections and recognised the challenge she had set for the organisation in continuing to deliver its strategy and plans for integrated healthcare. **The Board resolved that:** a) The Strategic Overview and Key Executive Activity to provide assurance described in the report was noted. b) The Strategic Leadership Team summary report was noted.	
UHB 26/07/6.4	**Finance & Performance Committee Chairs Report – click to view** Rhian Thomas (RT), Independent Member – Capital & Estates, introduced the report and provided an overview of the key matters discussed at the Committee meeting held the previous week. She advised that the Committee had reviewed the Month 3 financial position, which showed a year-to-date overspend of £27.0 million against a phased plan of £21.6 million, resulting in an adverse variance of approximately £5.4 million. She reported that delivery of the savings programme remained the principal financial risk, with only 41.8% of the £47.6 million savings target identified at that stage. RT noted that the target had increased by a further £5 million following the outcome of the Junior Consultants Committee (JCC) arbitration ruling and emphasised that significant progress was required to identify and deliver savings at pace. The Committee also considered operational performance, noting that periods of hot weather during June had resulted in business continuity pressures which had impacted urgent and emergency care and diagnostic waiting times and the Board was advised that a system-wide review of emergency care pressures experienced over the preceding eight weeks would be presented to a future Committee meeting. RT highlighted that delivery of the Quarter 1 Annual Plan remained broadly on track, with approximately half of actions rated green and none rated red. She also noted progress with implementation of the CSP and positive developments within public health programmes. The Committee further received updates on decarbonisation, where risks remained due to widening emissions gaps against Welsh Government targets, and on the Regional Partnership Board, including risks associated with the planned cessation of funding arrangements in March 2027. The Committee also approved the Strategic Outline Case for a new Haematology Facility and a revised Research & Development Income Management Policy. Rachna Upadhya (RU), Independent Member, highlighted a discrepancy between the financial deficit figures reported in the Chief Executive's Report and the Finance & Performance papers.	

	In response, Catherine Phillips (CP), Executive Director of Finance confirmed that the discrepancy had arisen from a transposition error within the Finance & Performance papers and apologised for the mistake. She clarified that the reported figure related to the actual year-to-date deficit rather than the savings gap. SLS referred to the Committee's discussion regarding workforce controls and recruitment management and asked whether sufficient assurance existed that there was a single source of truth for workforce planning and workforce costs across the organisation. RT acknowledged that further work was required and advised that the Committee had scrutinised the issue in detail. She noted that the Executive Team had recognised the need to reinforce existing controls and strengthen oversight arrangements. Paul Bostock (PB), Chief Operating Officer added that workforce numbers had remained static during Quarter 1 but acknowledged risks relating to future recruitment activity. He advised that the Strategic Leadership Team had subsequently agreed a series of actions to strengthen controls relating to temporary staffing, recruitment pipelines and workforce monitoring, and that compliance would be monitored on a weekly basis through Turnaround arrangements. RU sought further clarification regarding a reported £140,000 overcommitment within the Regional Partnership Board financial position and asked what contingency arrangements were in place should anticipated funding not materialise. RT advised that assurance had been provided to the Committee that the position would be managed through anticipated in-year programme slippage and was considered manageable within the overall financial profile. Stephen Riley (SR), Independent Member University noted that financial pressures risked becoming all-encompassing for the organisation and asked what proportion of future savings would be delivered through transformational change compared with short-term cost controls such as recruitment restrictions. He also sought assurance regarding discussions with Welsh Government on support for transformational change required to deliver the CSP. In response, CP advised that, given the point reached in the financial year, a greater proportion of savings were likely to come from short-term expenditure controls and turnaround measures than would ideally be the case. She stated that opportunities to accelerate transformational change would continue to be pursued, including through recently agreed capacity and bed reduction plans. CP also advised that discussions were ongoing with Performance and Improvement and Welsh Government regarding future support arrangements, although no formal support package had yet been agreed. **The Board resolved that:** a) The Finance & Performance Chairs Report was noted.	
UHB 26/07/6.5	**Board Assurance Framework – click to view** Matt Phillips (MP), Director of Corporate Governance reminded members that the previous Board meeting had focused on reviewing the strategic risk themes within the BAF. He advised that, whilst he had previously proposed bringing forward further work on mitigations at this meeting, a significant number of changes had since been made to the document. As a result, the focus of the report was on highlighting those changes and providing an opportunity for discussion. He noted that the key amendments had been set out within the report and invited questions from members.	

	Rachel Gidman (RG), Executive Director of People & Culture advised that a substantial number of changes had been made to the People agenda elements of the BAF. She explained that these amendments had been introduced deliberately through the work of the People and Culture Committee in order to strengthen focus and provide greater clarity in relation to workforce-related risks and priorities. She noted that further changes would be brought forward through future committee cycles. SLS referred to discussions previously held by the People and Culture Committee regarding implementation of the new Welsh Resident Doctor Contract and medical e-rostering. She noted that committee members had been advised that additional posts would be required to ensure compliance with the contract and sought an update on the anticipated cost implications, given that only broad estimates had previously been available. In response, David Fluck (DF), Executive Medical Director advised that the new contract represented a positive development as it would support safer medical rostering arrangements and improve oversight through the introduction of the Guardian of Safe Working arrangements. He explained that Welsh Government funding assumptions had been based on a 4% uplift; however, detailed modelling suggested that approximately 18 additional posts may be required to achieve compliance. DF advised that further work was underway with Finance colleagues to determine the exact impact and whether those requirements would be met through substantive appointments or bank arrangements. He indicated that the additional cost was currently estimated to be up to £1 million and would be reported through future meetings of the People and Culture Committee and Finance & Performance Committee. RG added that the detailed financial and operational implications were continuing to be worked through and that a further report would be presented to the relevant committees to ensure transparency and oversight. SLS acknowledged the update but emphasised the importance of ensuring that any additional costs associated with the new contract were accompanied by clear mitigation measures. She noted that assurance would be required regarding how the financial impact would be managed within the wider organisational financial position. David Thomas (DT), Director of Digital & Health Intelligence highlighted recent findings from the Audit Wales review of the Health Board's Digital Transformation Programme. He advised that whilst digital transformation remained critical to organisational success, significant risks persisted in relation to infrastructure, workforce skills and funding. He also noted that Audit Wales had recommended that Board members maintain strong oversight of the programme, support implementation of the recommendations and champion digital readiness across the organisation. In response, KW reflected that the Board should consider what support was required from Independent Members and the wider Board to help mitigate digital transformation risks. She invited further discussion on this matter through the appropriate governance structures. KW also questioned the fact that there had been no changes to the overall net risk scores within the BAF and asked whether this was expected or whether greater progress in risk mitigation should be reflected through reductions in risk scores. MP advised that, as the BAF was a strategic framework linked to the organisation's long-term strategy through to 2035, significant fluctuations in risk scores would not necessarily be expected from meeting to meeting. He explained that the BAF provided a strategic view of organisational risk themes and alignment between strategic objectives, portfolios and committee structures rather than serving as a dynamic operational risk register.	

	He contrasted the BAF with the organisation's operational risk management arrangements, noting that the Health Board's risk management system currently contained approximately 1,500 active risks that were actively managed and updated across services. He also advised that considerable work had recently been undertaken to strengthen risk management processes and that Executive colleagues had begun reviewing those risks to develop a more focused Corporate Risk Register containing the key organisation-wide strategic risks. MP confirmed that this work would be brought back to the Board in September for consideration. **The Board resolved that:** a) The Board Assurance Framework was reviewed and noted.	
UHB 26/07/6.6	**Committee Chairs Reports** The Committee Chairs Reports were received. **Charitable Funds Committee 16.06.2026** JRH advised that the Charitable Funds Committee had met on 16 June following a period during which there had been changes in Committee membership and staffing. She reported that the Committee had received a bi-annual update from the Health Board's investment manager, Rathbones, and had been assured that the charitable investment portfolio continued to perform satisfactorily. She further advised that the Committee had received a presentation from Noah's Ark Charity regarding its five-year strategy. She noted that opportunities had been identified to strengthen partnership working between the Health Board and Noah's Ark in the future. The Committee also received an update regarding the appointment of the new Head of Charity and JRH advised that the postholder had recently commenced in role and was already progressing work to develop a new charitable funds strategy, with further detail expected to be presented to the next Committee meeting. SR welcomed the appointment of the new Head of Charity and encouraged Executive colleagues to engage with her. She noted that the individual brought significant experience in community development, engagement and resilience and suggested that her expertise could contribute to a number of strategic priorities beyond the charitable funds agenda, including work associated with the CSP and community-focused approaches to improving health and wellbeing. RU sought clarification regarding the charitable investment portfolio, noting that whilst the investment portfolio had outperformed its benchmark, the general reserve remained in deficit. She asked how the two positions were connected. In response, CP explained that unrealised gains and losses from the investment portfolio were reflected within the general fund, but that the overall deficit position was influenced by a wider range of factors beyond investment performance alone. She advised that the Charitable Funds Committee had previously identified and been managing an underlying deficit position that had developed over a number of years and confirmed that plans were in place to improve the long-term sustainability of the charitable funds position and restore financial balance over time. **Quality Committee 30.06.2026** Ceri Phillips (CPVC), Vice Chair of the University Health Board and Quality Committee Chair advised that the Committee had undergone significant changes to its structure, reporting arrangements and format in order to better align its work with the delivery of the Health Board's strategic priorities and programmes.	

	He acknowledged that the revised arrangements remained in development and that some initial implementation challenges had been identified but reported that good progress was being made. He advised that the Committee had considered the development of quality performance indicators, which would support more timely and precise scrutiny of quality performance across the organisation. CPVC also reported that Clinical Board highlight reports had also been reviewed, identifying a number of recurring themes affecting quality and service delivery. The Committee noted workforce pressures as a common issue across a number of Clinical Boards. Estate-related challenges were also highlighted, particularly where infrastructure issues had implications for infection prevention and control. CPVC noted that healthcare-associated infections, including Clostridioides difficile infection, had featured within a number of discussions. He further advised that the Committee had reviewed progress against the Ophthalmology Review and had received assurance that significant improvements had been achieved, including reductions in long waits and improvements to patient experience. The Committee also considered progress relating to the Cardiac Devices Review and the Board was advised that members had sought assurance that the actions being implemented would provide sustainable long-term improvements rather than short-term solutions and that arrangements were in place to address the underlying issues that had led to the review. CPVC concluded that the revised committee arrangements were supporting more meaningful discussion and stronger scrutiny of quality issues. He reported that further refinements would continue but that early indications suggested the changes were resulting in significant improvements to the Quality governance agenda. **The Board resolved that:** a) The Chairs Reports were noted.	
UHB 26/07/6.7	**Strategic Planning, Commissioning and Partnership Update – click to view** Victoria Le Grys (VLG), Deputy Director of Strategic Planning & Partnerships advised that delivery of Quarter 1 Annual Plan actions remained broadly on track but reminded members that Welsh Government (WG) had confirmed that the Health Board did not have an approvable plan for 2026/27. She reported that work on the next planning cycle had commenced earlier than in previous years to allow greater engagement, learning and alignment with the recently launched CSP. The launch of the CSP was highlighted as a significant milestone and advised that work was now moving into delivery, particularly focusing on creating capacity for transformation through productivity, efficiency and turnaround programmes. VLG also highlighted progress with Community by Design and partnership working across South East Wales, including regional orthopaedic and cataract improvement programmes. Victoria Le Grice noted that uncertainty regarding future Regional Integration Fund arrangements beyond March 2027 remained a key risk. The Board also received an update from Lauranne Cullen (LC) from Llais. LC welcomed the inclusion of a dedicated Llais section within the report and highlighted the importance of strengthening feedback loops with the public. She advised that Llais had seen an increase in concerns being raised by members of the public and reported that approximately 62% of	

concerns were being resolved at an early stage through signposting and partnership working with the Health Board's Concerns Team.

She advised that the main themes emerging from patient feedback continued to relate to mental health, access to primary care, communication, waiting times and cancelled care. She noted that patients generally understood that waits would occur but were often frustrated by uncertainty and the lack of clear communication regarding timescales, changes in condition and who to contact if their circumstances worsened.

RT welcomed the revised format of the report and the inclusion of the Llais update, commenting that it provided a clearer and more informative overview for Board members. She suggested that future reports could include anonymised case studies and stronger descriptions of patient experiences to better illustrate the issues being raised.

SLS welcomed the Llais contribution and questioned how the organisation was learning from patient experiences, particularly in relation to cancelled appointments, waiting times and communication with patients. She asked whether there was a clear route for capturing learning and driving organisational improvement.

PB acknowledged that further work was required to improve communication with patients. Whilst highlighting that waiting times were reducing in a number of areas, he recognised that some patients were not experiencing these improvements and agreed that the organisation needed to provide clearer information and engagement.

LC added that patients were generally seeking certainty and reassurance rather than immediate treatment, noting the importance of providing clear timescales, regular communication and information regarding what patients should do if their condition deteriorated while waiting.

JRH commented on the increasing level of emotional distress and mental health concerns highlighted in the Llais report and questioned whether sufficient advocacy services were available to support individuals presenting in crisis.

In response, LC advised that Llais frequently signposted individuals to specialist advocacy and mental health support services but acknowledged that these services were also experiencing significant pressures. She reported an increase in safeguarding concerns and crisis-related contacts and noted the impact that this was having on both service users and staff.

Clive Curtis (CC), Independent Member Community, sought assurance that communities and patient groups were receiving feedback regarding how their input was being used to influence decision-making and service development.

In response, VLG advised that this had been identified as a key area for improvement. She reported that arrangements were being developed through the Shaping Our Future Wellbeing Collaborative to support ongoing engagement and provide feedback to stakeholders on how their views were informing delivery of the CSP.

Emma Cooke (EC), Executive Director of AHPs, Health Science & Community Development emphasised the importance of moving beyond consultation towards genuine co-production with patients, communities and partners. She advised that the Community by Design programme would provide an opportunity to improve how services were designed and accessed, particularly within community and primary care settings.

CPVC highlighted the importance of maintaining momentum and pace in delivering transformation programmes, noting the increasing expectation from Welsh Government that organisations move more quickly to implement new models of care.

In response to SLS' question regarding organisational learning from patient experience, Jason Roberts (JR), Executive Director of Nursing advised that the Health Board gathered

	feedback through a range of mechanisms including patient experience surveys, concerns and complaints. He acknowledged that this learning was not always visible and agreed to bring a future report to Board setting out how patient experience feedback was collected, used and translated into service improvements. **The Board resolved that:** a) The progress being made across the Strategy, Planning and Partnerships and Commissioning work programmes was noted.	
UHB 26/07/6.9	**Targeted Intervention Update – click to view** VLG advised that progress had continued across all targeted intervention domains and that there was now greater organisational alignment, stronger governance arrangements and clearer oversight of improvement activity. However, she cautioned that, whilst progress had been made, the Health Board was not yet able to describe itself as de-escalation ready. She explained that de-escalation would be assessed at overall domain level rather than against individual measures and that sustained improvement was required across all relevant criteria. VLG reported that feedback from the most recent Escalation Board meeting had highlighted the importance of maintaining delivery pace, organisational grip and continued progress against workforce, productivity and financial improvement plans. She noted that recent decisions around workforce controls, productivity and turnaround arrangements would support further progress ahead of the forthcoming Ministerial Accountability Meeting. CB advised that performance had improved in relation to vaccination measures and smoking cessation activity, with sustained growth in referrals to the Help Me Quit service over the previous six quarters. She reported that WG had indicated that continued progress could lead to consideration of de-escalation within that domain and described this as a positive development. KW sought assurance regarding how the organisation was bringing together the various improvement plans, de-escalation criteria, external requirements and service improvement programmes into a single coherent framework. She questioned how the organisation could ensure there was a clear plan with defined priorities, accountability and oversight. VLG advised that work was underway to develop an Integrated Improvement Plan. She explained that the intention was to create a single framework bringing together all improvement actions, external requirements and organisational priorities in one place. She reported that early work had already been undertaken to collate improvement actions and that further development would take place through the annual planning process. She advised that the aim was to provide a clear structure for ownership, performance monitoring and organisational communication, and noted that WG colleagues had already been engaged in reviewing the emerging approach. RU welcomed the positive direction of travel described within the report and noted it was encouraging that planning for 2027/28 had commenced earlier than in previous years. She asked how confident the organisation could be in future financial forecasts whilst uncertainty remained around the current year's financial position. She also sought clarification regarding the relationship between identified savings plans and savings already delivered. CP acknowledged that uncertainty remained regarding the final outturn position for the current financial year. She advised that the organisation was planning on the basis of its current position and assumptions whilst continuing work to identify the remaining savings required.	

	She emphasised that recurrent savings remained a key challenge and that reducing the underlying recurrent deficit would be an important focus going forward. She further clarified how identified savings plans were reflected within the financial reporting arrangements and how they contributed to reported savings delivery. CC recognised the considerable organisational effort being invested in responding to Targeted Intervention requirements and asked how the organisation was ensuring that operational teams retained sufficient capacity to focus on core services and clinical quality. In response, PB advised that the actions required through Targeted Intervention aligned closely with the organisation's fundamental operational responsibilities and objectives. He noted that improvements in access, waiting times and performance should also support quality improvements for patients. However, he acknowledged that the significant reporting, assurance and governance requirements associated with escalation did place additional demands on leadership capacity across the organisation. KW agreed that the volume of meetings and assurance processes associated with escalation created additional pressures on Executive colleagues and observed that achieving de-escalation would help reduce that burden and allow greater focus on service delivery. **The Board resolved that:** a) The UHBs current position performance position against its quantifiable de-escalation criteria was noted. b) Assurance was taken on the continued development of the IPR and the more seamless integration / insight this would bring to Board being able to effectively monitor progress towards de-escalation. c) The emerging findings of the Independent Assessors who had been working with the UHB and the further detail which had subsequently been provided to them ahead of their full and final report being submitted to Welsh Government was noted. d) The key areas of discussion at the last Escalation Board meeting with Welsh Government were noted.	
UHB 26/07/6.10	**Integrated Performance Report** The Integrated Performance Report (IPR) was received. KW noted that the new Integrated Performance Report contained considerably more information than previous reporting arrangements and acknowledged that further refinement of the report format may be required over time. **Quality & Safety** JR reported on key areas linked to the Targeted Intervention framework, including National Reportable Incidents (NRIs), Never Events and Infection Prevention and Control (IPC). He advised that 16 new National Reportable Incidents had been reported during June and that 89 incidents remained under review. He noted that significant work had been undertaken to improve the timeliness of investigations and reported that a substantial number of cases were expected to be closed shortly, reducing the number under review to approximately 60 and advised that five incidents had remained open for more than twelve months, which he acknowledged was unacceptable, although he noted these were particularly complex investigations. Work was underway to close three of these cases immediately, with the remaining two expected to conclude during August 2026. JR further reported that the Health Board had recorded eight Never Events during the previous 12-month period, predominantly relating to theatre procedures and medication errors. He advised that improvement work continued through the Theatre Together Programme, implementation of National Safety Standards for Invasive Procedures	

(NatSSIPs), and medication safety improvement programmes supported by electronic prescribing developments.

In relation to Infection Prevention and Control, JR advised that the Health Board had experienced a number of recent outbreaks, including Clostridioides difficile (C. difficile), MRSA and other infections. He reported that improvement plans were in place, supported by a comprehensive audit programme focusing on screening compliance, environmental cleanliness, hand hygiene and professional standards. He also highlighted plans to strengthen organisational communications and awareness campaigns relating to infection prevention.

PB clarified that the reported Never Events figure related to eight events over the previous twelve months. Whilst stressing that any Never Event was unacceptable, he advised that benchmarking with comparable organisations suggested Cardiff and Vale's performance was not significantly different from other large and complex healthcare providers. He further noted that improvements in staff confidence to speak up and report incidents may partly explain current reporting levels.

RT welcomed the focus on reducing the number of open National Reportable Incidents and sought assurance that improvements would be sustainable. She also asked whether individual accountability arrangements were in place for the management of long-running investigations.

JR advised that he was confident the number of open investigations would reduce significantly and that strengthened Executive oversight was supporting progress. He confirmed that individual leads and investigation chairs were appointed for each investigation, although delays could occur where investigations were particularly complex, involved multiple organisations, or where key staff changed during the investigation process. He reiterated his expectation that no investigations should remain open beyond twelve months.

CPVC noted that the development of the Quality Management System (QMS) would further support improvements and contribute towards achieving targeted intervention requirements relating to quality governance.

DF then provided an update on mortality reporting. He advised that the Medical Examiner process was now well established and that mortality and morbidity reviews had been standardised across the organisation. He reported that crude mortality rates had reduced over the previous year, whilst noting that risk-adjusted measures provided a more meaningful assessment of performance.

He highlighted improvements in the Risk Adjusted Mortality Index (RAMI), although he acknowledged that performance remained above the benchmark level and further improvement was required. He also provided updates on stroke mortality and hip fracture mortality, both of which had been identified as areas of focus through targeted intervention arrangements.

Whilst reporting some positive trends and improvements in supporting care processes, he advised that further analysis was ongoing to better understand factors contributing to mortality outcomes and to identify additional improvement opportunities.

KW welcomed the increased level of detail within the mortality reporting and noted the importance of linking this information to both targeted intervention requirements and wider organisational risk management arrangements.

Digital

DT advised that the Digital section of the Integrated Performance Report remained under development and that a fuller suite of performance measures would be incorporated into future reports. These would include measures relating to IT service desk performance,

infrastructure availability, Wi-Fi coverage, device deployment and Information Governance training compliance.

He highlighted progress made within the Business Intelligence function, noting that the Health Board had successfully reduced its reliance on external providers for reporting and data analytics. He advised that the organisation was now increasingly able to produce its own reports and performance insights to support operational and service planning decisions.

He also reported that the Health Board had secured WG digital prioritisation funding to support implementation of the OpenEyes Electronic Patient Record system and the expansion of the BadgerNet maternity electronic patient record system into neonatal services.

Population Health

CB highlighted the significant health inequalities that exist across Cardiff and the Vale of Glamorgan and advised that reducing these inequalities remained central to delivery of the Health Board's strategy.

She emphasised that prevention was a key tool in reducing future demand on health and care services and improving long-term outcomes.

The update focused on three key prevention priorities: vaccination, smoking cessation and obesity prevention.

CB reported continued improvement in childhood and teenage vaccination uptake, with performance moving closer to the Welsh average. She advised that a Childhood and Teenage Immunisation Strategic Plan had been developed in collaboration with primary care, local authority and Health Board partners to support further progress.

In relation to smoking cessation, it was reported sustained growth in engagement with the Help Me Quit service, with referrals increasing significantly compared to previous years. She noted that work was continuing with primary care, healthcare services and community partners to increase access to smoking cessation support.

CB also provided an update on obesity prevention and advised that the Health Board's Good Food and Movement Plan was focused on creating long-term system change through partnership working. She noted that whilst weight-loss medications could support individuals to lose weight, wider environmental and behavioural factors also needed to be addressed to achieve sustainable improvements.

The Board was advised of ongoing work in response to cases of Hepatitis A identified in the Barry area, with vaccination and public health measures being implemented in partnership with Public Health Wales and local authority colleagues.

PB referred to comments regarding weight-loss medications and asked whether there was robust evidence demonstrating that individuals commonly regained weight after discontinuing treatment.

In response, CB advised that recent published evidence demonstrated that many individuals regained weight after stopping treatment and undertook to share the relevant research paper with Board members.

EC added that further evidence was available regarding the risks associated with use of weight-loss medications without appropriate clinical support and oversight and agreed to share this information with members.

SLS raised concerns regarding misinformation circulating on social media about the Hepatitis A outbreak in Barry and asked what action was being taken to ensure that accurate public information was available.

CB acknowledged the issue and advised that further work would be undertaken with the Communications Team to strengthen public messaging and ensure information about the outbreak, associated risks and prevention measures was communicated clearly.

KW asked for assurance regarding the Health Board's preparedness to deliver the recently introduced meningitis B vaccination programme for young people entering higher education.

CB advised that arrangements were in place to deliver the programme through schools and in partnership with universities and colleges. She confirmed that the Health Board would continue to implement all vaccination programmes in line with recommendations from the Joint Committee on Vaccination and Immunisation (JCVI) and WG guidance.

Finance

CP advised that the key financial risk facing the organisation remained delivery of the savings programme. She noted that the Board had already discussed the financial position in detail through the Finance & Performance Committee Chair's Report and Targeted Intervention Update earlier in the meeting.

She reiterated that the principal challenge continued to be identifying and delivering the remaining savings required to achieve the organisation's financial plan, whilst also improving the recurrent financial position.

People & Culture

RG reminded members that the Health Board's key workforce priorities remained reducing sickness absence, strengthening leadership and management capability, and improving workforce planning arrangements.

She reported that sickness absence remained a significant area of focus, with a rolling 12-month rate of 6.4%, although more recent performance had fallen below 6%.

The Board was advised that a range of interventions were being implemented, including enhanced scrutiny of high-absence areas, management training and a new management passport programme to improve managers' confidence in applying people policies.

RG highlighted national work being undertaken by NHS Wales Workforce Directors to share learning and identify effective approaches to reducing sickness absence.

Temporary staffing expenditure was highlighted, advising that additional scrutiny was being applied to bank and agency usage to ensure appropriate workforce controls and value for money.

RG noted that Executive colleagues were working closely with Clinical Boards to improve oversight and reduce expenditure where possible.

The Board was also advised of ongoing work to improve workforce equality data, particularly relating to Welsh language skills, and preparations for the forthcoming NHS Staff Survey.

RG highlighted a range of staff engagement activities and workforce development initiatives, including the Bridging Futures programme, which provided employment opportunities and work experience for individuals receiving Universal Credit.

RT noted that employee relations activity remained elevated and asked whether this reflected worsening workplace issues or whether other factors were contributing to the increase in case numbers.

In response, RG advised that increases had been anticipated as a result of work undertaken to encourage staff to speak up and report concerns, particularly in relation to

respect, resolution and sexual safety. She explained that greater awareness and confidence in organisational processes were likely contributing to increased reporting levels.

She added that the organisation was seeking to reduce the length of time taken to investigate and resolve cases through enhanced monitoring and improved case management arrangements.

PB supported the comments and advised that the increase in reported employee relations cases should not necessarily be viewed negatively. He noted that the organisation had become more proactive in addressing poor behaviours that may previously have gone unchallenged and stressed the importance of ensuring concerns were investigated and resolved in a timely manner. He added that further work was underway to support investigating officers and strengthen the overall process.

KW emphasised the importance of maintaining organisational standards and ensuring concerns were addressed consistently and without unnecessary delay.

Operational

PB advised the Board that operational performance remained mixed, with some areas demonstrating improvement whilst significant challenges remained in urgent and emergency care, planned care and diagnostics.

He reported that performance during June 2026 had been impacted by periods of hot weather and increased demand, which had placed additional pressure on patient flow and hospital capacity.

It was highlighted that continued progress in reducing long waiting times, including improvements in ophthalmology performance and reductions in the numbers of patients waiting over two years. PB advised that work continued across a number of specialties to improve access and reduce backlogs, supported by regional working arrangements and transformation programmes.

In relation to urgent and emergency care, PB reported that performance against the 4-hour Emergency Department target remained below expectations and that ambulance handover delays continued to be a significant challenge. He advised that a review of recent system pressures was underway to identify learning and further improvement actions.

SLS acknowledged the progress being made in reducing long waits but questioned whether sufficient focus was being placed on improving patient experience while individuals remained on waiting lists.

In response, PB agreed that reducing waiting times alone was not enough and advised that work was continuing to improve communication with patients, provide clearer information regarding expected waits and support patients whilst awaiting treatment.

RT sought assurance regarding the sustainability of recent performance improvements and asked whether there was confidence that improvements could be maintained during periods of increased operational pressure.

PB advised that whilst there had been encouraging progress in a number of areas, performance remained fragile and continued to rely on strong operational grip, workforce availability and sustained delivery of improvement actions. He noted that further work was required to embed improvements on a recurring basis.

KW commented on the importance of maintaining momentum in delivering the CSP and transformation programmes, noting that operational recovery and service redesign needed to progress alongside one another.

	In response, PB agreed that operational performance, turnaround activity and implementation of the Clinical Services Plan were closely linked. He advised that the organisation's focus remained on creating capacity and improving productivity in order to support both performance improvement and longer-term transformation. In conclusion, KW requested that Board members provide feedback on the new IPR format which would help to inform future reports. **The Board resolved that:** A) The revised approach and ongoing developments to the Integrated Performance Report were noted. B) The position against key organisational performance indicators for 2026-27 and the update against the Operational Plan programmes were noted.	
UHB 26/07/6.12	**An Overview of Genomic Partnership Wales (GPW) – click to view** **Part two of the meeting (click to view)** SR introduced the item, noting the growing importance of genomics in supporting earlier diagnosis, personalised treatments and improved patient outcomes across a wide range of clinical specialties. Michaela John (MJ), Head of Programme - Genomics Partnership Wales provided an overview of the Genomics Partnership Wales programme and its role in delivering genomic services across Wales. She explained how advances in genomic testing were increasingly being used to support the diagnosis and treatment of rare diseases, cancer and a range of inherited conditions. She advised that genomic medicine was becoming a routine part of healthcare delivery and highlighted the importance of ensuring equitable access to services across Wales. The presentation outlined progress made in expanding genomic testing capacity, developing the workforce and integrating genomics into clinical pathways and also highlighted the contribution of research and innovation programmes, including participation in UK-wide initiatives, to improve understanding of disease and support future developments in personalised medicine. SLS welcomed the presentation and asked how genomic services were being made accessible to patients and clinicians across all parts of Wales, particularly given the specialist nature of the service. In response, MJ advised that genomic services were delivered on an All-Wales basis through a networked approach and that significant work had been undertaken to support clinicians through education, training and clear referral pathways. She noted that the aim was to ensure patients could access genomic services regardless of where they received their care. RT asked how genomic medicine was influencing clinical decision-making and whether tangible benefits for patients were now being realised. MJ advised that genomic testing was already enabling earlier and more accurate diagnoses in a number of specialties, reducing diagnostic delays for some patients and supporting more personalised treatment decisions, particularly within cancer services and rare disease pathways. KW reflected on the pace of development within genomic medicine and questioned how the Health Board could ensure it remained prepared for future advances in technology and clinical practice. MJ emphasised the importance of workforce development, digital infrastructure and continued partnership working at a national level. She noted that genomics would	

	increasingly become part of mainstream healthcare and that ongoing education and service transformation would be required to support that. **The Board resolved that:** a) It was noted that the Board had a developing awareness of the national genomics programme and CAVUHB's leadership role and hosting responsibilities. b) The Board were assured that the Programme was accorded the appropriate governance and oversight. c) The Board was assured that continuity plans were in place. d) The Board considered how it would like to maintain oversight of the Programme.	
UHB 26/07/7.1	**Capital Plan 2026/27 – click to view** CP advised that the capital plan had been substantially developed alongside the organisational planning process, with further work undertaken to reflect Clinical Board priorities and Welsh Government requirements. She reported that the plan represented the Health Board's approach to prioritising available capital resources and sought Board approval of the proposed programme. RT asked for clarification regarding the increase in discretionary capital funding and queried what had driven the additional allocation. CP advised that Welsh Government had increased the discretionary capital funding available to Health Boards and that Cardiff and Vale UHB had also successfully argued for an enhanced allocation reflecting its role in hosting a number of all-Wales services. She added that whilst the increase was welcome, the available funding remained insufficient to address the scale of estate challenges facing the organisation. SLS referred to risks identified within the report relating to the deteriorating estate and asked whether the Health Board had a clear long-term vision for its estate, including future developments, site utilisation and investment priorities. In response, CP advised that the organisation continued to work within its existing estate strategy, alongside the CSP and Community by Design programme. She explained that the greatest estate risks remained concentrated at University Hospital of Wales (UHW) and that work was underway to develop a vision document for the future of the UHW site. She also highlighted ongoing work to review estate utilisation, identify opportunities for rationalisation of surplus estate and consider future community-based facilities in partnership with local authorities and other public sector organisations. PB commented that much of the capital programme was necessarily focused on essential infrastructure works rather than visible service improvements. He noted that the majority of investment related to maintaining safe services through works such as fire safety, legionella management, asbestos remediation and critical infrastructure replacement, rather than new developments that staff and patients would immediately recognise. KW sought clarification regarding timescales for the estate vision work and questioned whether the existing estate strategy should be formally refreshed, given that it had reached the end of its original timeframe. CP advised that the vision document for the UHW site was expected to be completed during the next quarter, with a supporting action plan to follow later in the year. She explained that the principles within the existing estate strategy remained valid and continued to guide decision-making, although delivery had taken longer than originally envisaged. **The Board resolved that:**	

	a) The content of the paper was noted. b) The draft capital plan 202627 was approved.	
UHB 26/07/7.2	**Local Trauma and CranioMaxillofacial Contract – click to view** CP advised the Board that the procurement exercise had been undertaken jointly by clinical teams and procurement colleagues with the aim of standardising products, reducing unwarranted clinical variation and securing value for money. She explained that, whilst there would always need to be some flexibility within trauma and emergency care, the contract would support greater consistency in practice across the service. She further advised that the contract was already accommodated within existing budgets and, importantly, was expected to deliver a financial saving to the Health Board. As the contract value exceeded the Board approval threshold, formal Board approval was required before progressing the award through the relevant Welsh Government processes. **The Board resolved that:** a) The award of the Local Trauma and Craniomaxillofacial Contract to Johnson & Johnson Depuy Synthes was approved.	
UHB 26/07/8.1	**Consent Agenda Items** **8.1 Park View Update** The Board received the Park View Update **The Board resolved that:** a) The contents of the paper were noted. b) The changes to the contract 'pain/gain' mechanism as proposed and the use of £200k of the project contingency to increase the agreed target cost to £30.978m inclusive of 20% VAT from the FBC agreed Target cost of £30.738m inclusive of 20% VAT was approved. c) The appointment of Kier Construction Ltd, as the Supply Chain Partner to deliver the construction of the Wellbeing Hub at Parkview at a cost of £30.978m incl.20% VAT under the terms and conditions NEC3 contract, Option C, Engineering and Construction Contract was approved. **8.2 Haematology Strategic Outline Case** The 8.2 Haematology Strategic Outline Case was received. **The Board resolved that:** a) The content of the paper was noted. b) The Strategic Outline Case (SOC) as included at appendix 1, for the provision of a new inpatient facility to deliver Haematology services including BMT and CAR-T in line with JACIE standards was endorsed. c) The SOC was approved for formal submission to Welsh Government to seek capital investment and it was approved to progress a combined Outline Business Case/Full Business Case. d) The impact to patients and the reputational risk to the Health Board with the loss of JACIE accreditation was noted. **8.3 Quality Management System (QMS) Improvement Plan** The Quality Management System (QMS) Improvement Plan was received. **The Board resolved that:** A) The Quality Management System Organisational Development Plan was approved.	
UHB	**Reports from Advisory Groups and Joint Committees**	

26/07/9.1	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 26/07/9.2	**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 26/07/11	**Any Other Business** No other business was raised.	
UHB 26/07/11.2	**Time & Date of the next Meeting:** 24 September 2026, Microsoft Teams	

MEETING	Title	Minute Reference	Agreed Action	Executive Lead	Action Lead	Date Assigned	Date for Review	Action Status	Action Update	Comments
PUBLIC BOARD	Integrated Performance Report	UHB 26/07/6.10	Develop and implement a plan to reduce the number of long-outstanding National Reportable Incident investigations, including closure of investigations exceeding 12 months where appropriate, and provide ongoing assurance through established reporting arrangements.	Jason Roberts	Jason Roberts	30/07/2026	24/09/2026	COMPLETE	Updates are now provided through the Integrated Performance Report.	
PUBLIC BOARD	Integrated Performance Report	UHB 26/07/6.10	Bring a report to Board setting out how patient experience feedback, concerns, complaints and engagement intelligence are collected, analysed and translated into service improvements. Date required from Jason Roberts (September or November)	Jason Roberts	Jason Roberts	30/07/2026	26/11/2026	ON FORWARD PLAN	On Forward Plan for 26th November Board meeting.	
PUBLIC BOARD	Strategic Planning, Commissioning and Partnership Update	UHB 26/07/6.7	Develop an Integrated Improvement Plan bringing together targeted intervention requirements, improvement actions, planning priorities and accountability arrangements into a single organisational framework.	Adam Roberts	Victoria Legrys	30/07/2026	24/09/2026	ON FORWARD PLAN	The development of the Integrated Improvement Plan continues and a further update will be provided to Board Members at Board Development sessions and future Board meetings.	
PUBLIC BOARD	Capital Plan 2026/27	UHB 26/07/7.1	Consider the governance route for formally refreshing/re-adopting the Estate Strategy and bring proposals through the appropriate Committee and Board structure.	Catherine Phillips	Matt Phillips, Geoff Walsh	30/07/2026	24/09/2026	ON FORWARD PLAN	On Forward Plan for 29th October Board Development	
PUBLIC BOARD	Board Assurance Framework	UHB 26/07/6.5	Bring forward the developing Corporate Risk Register and revised strategic risk arrangements for Board consideration.	Matt Phillips	Matt Phillips	30/07/2026	24/09/2026	ON FORWARD PLAN	On agenda for 24th September 2026 for Board approval.	

Report Title:	**Chair's Report to Board**				Agenda Item no.	6.2
Meeting:	**Public Board**	Public	X		Meeting Date:	**24 September 2026**
		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:

Shaping Our Future
Wellbeing

Welcome / Croeso

This report provides an overview of key activities undertaken in my capacity as Chair since the last Board meeting, highlighting significant Board business, stakeholder engagement and matters of strategic importance to the Health Board.

Throughout what has been a busy summer period for the Health Board, I have been continually impressed by the dedication and commitment shown by colleagues across Cardiff and Vale. August also marked an important milestone for the organisation with the arrival of our new interim Chief Executive, Chris Bown who took up post on 3 August. Since joining us, Chris has spent considerable time meeting staff, visiting services and engaging with partners and stakeholders across the region. These visits and conversations are helping to strengthen relationships, understand local priorities and identify opportunities for collaboration as we continue our collective efforts to improve health services and outcomes for our communities.

I am delighted to announce the launch of the Healthcare Professionals' Forum (HPF) and invite expressions of interest for the inaugural Chair role. The establishment of the HPF is a significant milestone for the Health Board, creating a formal mechanism through which the expertise, insight and experience of healthcare professionals can directly inform Board discussions, strategic decision-making and service transformation. The successful Chair will join the Board as an Associate Member, ensuring that the professional voice is represented at the highest level of organisational leadership.

The Independent Assessors highlighted the importance of listening to and acting upon the views of our workforce. The HPF responds directly to that challenge by strengthening clinical and professional engagement, bringing together multidisciplinary perspectives from across the organisation and ensuring that colleagues have a meaningful and influential role in shaping the future of our services. Through constructive challenge, professional insight and collective leadership, the Forum will help inform key decisions on healthcare strategy, service planning and delivery.

At a time when the Health Board is undertaking significant organisational redesign and service transformation, it is essential that professional voices are connected, heard and able to influence change. The HPF represents an important step in strengthening our governance arrangements,

supporting a more inclusive approach to decision-making, and embedding the engagement and cultural improvements expected following the Independent Assessment. Further information is available via the Healthcare Professionals' Forum Chair recruitment page

Listening to our Staff and Patients

In Conversation

I joined Chris Bown for the first of a new series of "In Conversation" staff engagement events in August. With more than 500 colleagues taking part, the session provided an opportunity to discuss the findings of the Independent Assessment and hear directly from staff on issues including leadership, culture, engagement and patient outcomes. I was particularly encouraged by the openness of the discussion and the enthusiasm shown by colleagues to contribute to the ongoing improvement journey of the Health Board. Open and honest dialogue with staff will be critical to our improvement journey. I would encourage colleagues to continue engaging through future *In Conversation* sessions and the associated Viva Engage community, helping to ensure that staff voices remain central to the development of our services, culture and priorities for the future.

Visit to the Hospital Sterilisation and Decontamination Unit (HSDU)

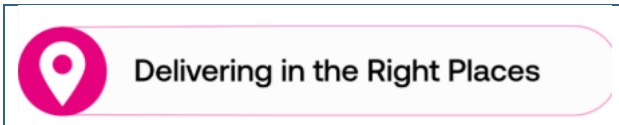


During August, I returned to the Hospital Sterilisation and Decontamination Unit (HSDU), this time accompanied by our interim Chief Executive Chris Bown. Having visited the service earlier this year, it was valuable to hear directly from colleagues again and receive an update on progress, challenges and priorities within this critical service.

HSDU plays an essential role in supporting the safe delivery of care across the Health Board. Our discussions reinforced the impact that ageing infrastructure and estates pressures can have on frontline services and the importance of continued investment to improve resilience and reliability across our estate. As the Board has recently acknowledged, addressing longstanding infrastructure challenges remains a key priority, and repeat visits such as this help ensure that our understanding is informed by the experiences and expertise of the staff who work within these environments every day. I am grateful to the HSDU team for their openness, professionalism and continued commitment to patient care.

Senior Medical Staff Committee (SMSC)

I am pleased to welcome George Eralil as the new Chair of the Senior Medical Staff Committee. The Committee provides an important forum for senior medical colleagues to contribute to organisational improvement and the development of clinical services. As the Board continues to strengthen communication, engagement and collaborative working with our consultant body, I look forward to working with George and the Committee to support these shared ambitions.





Welsh Government and National Priorities

Performance & Improvement Independent Advisors

Following publication of the Independent Assessment report of the Health Board provided by NHS Wales Performance & Improvement, the Chief Executive and I have continued to engage with the Independent Advisors and wider partners to ensure that the findings are translated into meaningful and lasting improvement. We are grateful to the Advisors for their comprehensive assessment and the constructive recommendations provided. The report offers an important opportunity to reflect honestly on our current position, build on the many strengths identified, and accelerate improvements in leadership, culture and governance.

The Health Board is fully committed to learning from the findings and responding at pace. The recommendations will be incorporated within a single, overarching improvement plan, bringing together actions from the Independent Assessment alongside existing improvement and escalation programmes. This will support a coordinated approach to delivery, provide clear oversight and accountability, and ensure that progress remains focused on improving outcomes and experiences for patients, communities and colleagues.

The Board will closely monitor delivery of the improvement plan and hold itself accountable for progress. As Chair, I will seek ongoing assurance that the recommendations are being implemented effectively and are delivering meaningful improvements for our staff, patients and communities.

In August, I met with Sarah Rees MS, Member of the Senedd for Bridgend and the Vale of Glamorgan, as part of my ongoing programme of stakeholder engagement. The meeting provided a valuable opportunity to strengthen relationships with elected representatives, discuss the Health Board's priorities and improvement journey, and share insights into the work underway to improve services for the communities we serve. Maintaining strong and constructive engagement with key stakeholders remains an important part of ensuring transparency, building confidence and supporting the Health Board's wider strategic objectives.

In August, I had a meeting to discuss the NHS Wales Veterans' Service with Gareth Thomas MS. The visit provided an opportunity to meet Gwen OConnor Consultant Clinical Psychologist and the team to learn more about the specialist support provided to veterans, and discuss the importance of ensuring the needs of this community continue to be reflected in service development and planning. The meeting also supported ongoing engagement with elected representatives and helped raise awareness of the valuable work being delivered by the service.

Over the summer I joined fellow NHS Wales Chairs at a workshop exploring the development of a Welsh Well-led Framework. The proposed framework aims to provide a shared approach to strengthening leadership, governance, culture and organisational effectiveness across NHS Wales, whilst recognising the unique characteristics of the Welsh system.

The session provided a valuable opportunity to reflect on the principles of well-led organisations, which are already familiar to Cardiff and Vale UHB through previous Board Development

discussions. As we continue our improvement journey, these principles remain highly relevant in supporting strong leadership, organisational culture and sustained improvement in outcomes for our patients, communities and staff.

Providing Outstanding Quality

National Exercise Referral Scheme (NERS)



In August, I visited a National Exercise Referral Scheme (NERS) Tai Chi class at Barry Leisure Centre, seeing first-hand how community-based wellbeing initiatives are helping people improve their physical health, mobility and overall wellbeing. It was encouraging to hear from participants about the positive impact the programme has had on their confidence, independence and quality of life.

The visit highlighted the important role that prevention, early intervention and healthy lifestyle support play in improving population health and reducing health inequalities. Initiatives such as NERS demonstrate how the Health Board and its partners can support people to stay well, remain active and live independently for longer. This aligns closely with our strategic objective of providing outstanding quality, particularly through promoting prevention, improving health outcomes and supporting individuals to take an active role in their own health and wellbeing.

Domestic Abuse Commissioner Visit

I was pleased to welcome Dame Nicole Jacobs, Domestic Abuse Commissioner for England and Wales, to Cardiff and Vale University Health Board in July where she met colleagues from across our Emergency Department, Safeguarding Hub, Violence Prevention Unit, Independent Domestic Violence Advisor service, South Wales Police and partner organisations. The visit provided an important opportunity to showcase the collaborative and person-centred approach being taken across the Health Board and our partners to support individuals affected by domestic abuse.

Through visits to frontline services and a multidisciplinary roundtable discussion, Dame Nicole heard how colleagues work together to identify those at risk, provide timely interventions and connect individuals with specialist support. Feedback from the visit was highly complimentary and recognised the strength of partnership working, innovation and commitment demonstrated by our teams in delivering compassionate care and safeguarding some of the most vulnerable people in our communities.



This visit provided valuable external recognition of the work being undertaken across Cardiff and Vale and reflects our commitment to delivering Outstanding Quality through safe, effective and person-centred services. It also highlighted the vital contribution that partnership working makes to improving outcomes, reducing harm and ensuring that those affected by domestic abuse receive the support they need at the right time.

Board Development Session – 27 August 2026

In August, the Board held a development session focused on the Health Board's improvement journey, reflecting on the findings of the Independent Assessment and the actions being taken to strengthen governance, culture, leadership and organisational delivery. The Board considered progress in responding to the Independent Assessors' recommendations and preparations for forthcoming Welsh Government accountability and escalation discussions.

The session also included engagement with the NHS Wales Joint Commissioning Committee on the planning and delivery of specialised services across Wales, together with a detailed discussion on the approach to developing the 2027/28 Annual Plan. Board Members considered the emerging organisational priorities, planning assumptions and the need to align quality, workforce, finance, performance and transformation within a clear and deliverable programme of change.

Importantly, these discussions were closely linked to the Health Board's organisational redesign programme and the ambition to strengthen the foundations of leadership, governance, planning capability and clinical engagement across the organisation. The Independent Assessors highlighted the need for stronger organisational grip, clearer accountability and greater engagement with staff and clinical leaders. The Board's discussions therefore focused not only on what needs to improve, but how we create the conditions for sustainable improvement. Together, the organisational redesign, our response to the Independent Assessment and the development of the 2027/28 Annual Plan provide a coherent framework for driving forward the changes needed to improve services, strengthen organisational culture and support our journey towards de-escalation.

Recognising Excellence

Acting for the Future

Therapists swap cars for e-bikes to visit patients across Cardiff



I would like to recognise the innovation and commitment demonstrated by colleagues from the Cardiff Community Resource Team who have been trialling the use of electric bikes to undertake patient visits across Cardiff over the summer. The pilot was developed to explore more sustainable ways of delivering care whilst continuing to support patients in their own homes and helping them maintain independence

The project highlights how colleagues are embracing innovative approaches that deliver benefits for patients, staff and the environment. During the first two months of the pilot, the team collectively cycled more than 300 miles, reducing car journeys while also promoting healthy lifestyles and active travel through conversations with patients. The initiative demonstrates how small changes in the way we work can contribute to a more sustainable NHS while maintaining high-quality care closer to people's homes.



This is an excellent example of our strategic priority of Acting for the Future in practice, demonstrating how innovation, sustainability and prevention can work together to improve services today while helping to create a healthier and more sustainable future for our communities.

I would like to congratulate everyone involved in this initiative. It is a fantastic example of colleagues thinking creatively about how we can deliver high-quality care in a way that is sustainable, innovative and focused on the future. Their enthusiasm and commitment demonstrate the difference that staff-led innovation can make, and I look forward to seeing how the learning from this pilot can inform future approaches across the Health Board.

KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

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 **3** documents since as listed below;

Seal No.	Description of documents	Date Sealed
1140	Parkview Wellbeing Hub Confirmation Notice 2 for National Supply Chain Partner	18.08.2026
1141	Lease between Cardiff and Vale ULHB and British Pregnancy Advisory Service (BPAS) relating to Cerys Ward, Llandough Hospital, Penlan Road, Llandough, Penarth	20.08.2026
1142	Telecoms Tower Lease - University hospital of Llandough	27.08.2026

The following **2 x Legal Documents** are reported as having been signed on behalf of the Health Board;

Date Signed.	Description of documents	Value Information
20.08.2026	Lease between Cardiff and Vale ULHB and British Pregnancy Advisory Service (BPAS) relating to Cerys Ward, Llandough Hospital, Penlan Road, Llandough, Penarth	12 Months Income - £150,000.00
27.08.2026	Telecoms Tower Lease - University hospital of Llandough	£3000 per annum

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

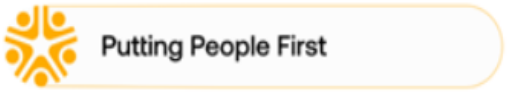
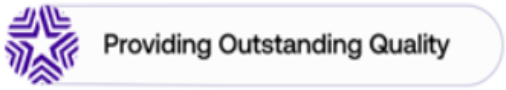
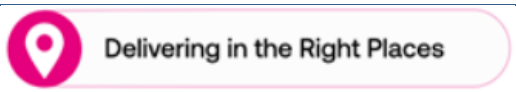
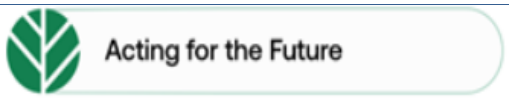
Date Received	Description of documents	Background information	Date Approved
13.08.2026	Parkview Wellbeing Hub Confirmation Notice 2 for National Supply Chain Partner	between Cardiff and Vale Local Health Board and Kier Construction Limited trading as Kier Construction Western and Wales £28.22m under the T&Cs if NEC3 contract	18.08.2026
01.09.2026	Financial Turnaround Delivery Partner appoint an experienced Financial Partner to establish and operate an Executive Financial Turnaround Delivery Office. The contract is to provide practical, embedded financial turnaround and implementation support.	Initial Term Mid Sept - Mid Dec 2026 £781,830.00 excluding VAT £950,196.00 including VAT Extension Mid Dec - Mid Jun 2027 £2,169,740.00 excluding VAT £2,603,688.00 including VAT	01.09.2026

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/*			
 **Click the objective above to view more detail.**		 **Click the objective above to view more detail.**	
 **Click the objective above to view more detail.**		 **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	

Report Title:	**Chief Executive's Report to Board**				Agenda Item no.	6.3
Meeting:	Public Board		Public	x	Meeting Date:	24 Sept 2026
			Private			
Status *(please tick one only):*	Assurance	X	Approval		Information	
Lead Executive:	Chief Executive					
Report Author (Title):	Head of Corproate Governance					

Main Report

Shaping Our Future Wellbeing

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

Initial Reflections

I joined the Health Board as Interim Chief Executive on 3 August. My focus during the first month has been straightforward: to listen, understand the organisation and hear directly from colleagues before determining where change is required.

I have spent time with staff across a wide range of services, including Portering and Security, Sexual Health, Cardiff and Vale Drug and Alcohol Service, Mental Health Services, Theatres, the Emergency Department, Medical Records, Maternity services and the Food Production Unit, as well as visiting teams at Whitchurch Hospital, Cardiff Prison and many sites across the organisation. These conversations have provided valuable insight into both the strengths of the organisation and the challenges we need to address. Colleagues have been open and honest about their experiences, and I have been struck by their professionalism, commitment and determination to provide the best possible care despite significant pressures. The undeniable fact is that we are blessed with an abundance of talented and motivated people!

My early observations are that there is much to build on, including committed staff, strong services and a shared desire to improve. Equally, there are clear opportunities to strengthen performance, accountability, communication and the experience of both staff and patients. Everyone I have spoken with has demonstrated a massive commitment to the patients of Cardiff and the Vale. I have appreciated honesty about the challenges we all face together and I know the leadership team along with the Board will be focused on making the improvements needed working closely with colleagues over the coming months.

The engagement I have undertaken during my first month will continue. Listening to staff and understanding the realities of frontline services will be essential as we take forward our improvement programme and work together to deliver the changes needed across the Health Board. I will now focus on establishing the conditions needed to achieve success.

Performance at a Glance

Criteria	Indicator	Position	Trend	Commentary
Quality				
Infection	Cumulative number of C. difficile infection cases	Apr-26 to May-26: 26 Apr-26 to Jun-26: 44 Apr-26 to Jul-26: 61 *All Wales Target* 31 49 70	►	Focused work continues through the C. difficile Collaborative, prevention campaign, education tool and prompt isolation. Cases are eight below the same period in 2025, with rollout and uptake monitoring continuing.
Infection	Cumulative number of hospital onset E.coli BSI cases	Apr-26 to May-26: 13 Apr-26 to Jun-26: 21 Apr-26 to Jul-26: 33 *All Wales Target* 9 16 23	▼	Hospital-onset E. coli cases are 10 above the same period in 2025. Actions include All Wales UTI engagement, CSARO compliance and catheter practice audits, with education tool development underway.
Complaints	Performance for all complaints	July 26: 77% Aug 26: 72%	▼	All complaints performance remains positive, with 87% managed through Early Resolution, supporting timely local resolution and service learning.
Public Health				
Vaccination	% of children up to date with scheduled vaccinations by age 5 to be in line with the all-Wales average	Q4 25/26: 85.0%, Target 87.5% Q1 26/27: 83.6%, Target 87.2%	▼	Work ongoing to close the gap to Wales average
Delivery/Performance				
Cancer	% of patients starting first definitive cancer treatment within 62 days from point of suspicion	Apr-26: 61.7% May-26: 60.9% Jun-26: 63.6% De-escalation *target 60%* *Standard Cancer Pathway target 75%*	►	Improvement continues despite rising demand, with four months above 60% SCP compliance and June at 63.6%. Capacity and tumour-site recovery actions are progressing towards the 75% ambition by March 2027.
Planned Care	% of open pathways waiting less than 52 weeks for a new outpatient appointment	Apr-26: 89.5% May-26: 89.8% Jun-26: 90.0% De-escalation *Target 100%*	▼	52-week outpatient waits are improving, supported by validation, See on Symptom and Patient Initiated Follow Up pathway conversion, additional capacity and active pathway management.
Diagnostics	% of patients waiting less than 8 weeks for diagnostic test	Apr-26: 61.8% May-26: 56.1% Jun-26: 54.5% De-escalation *Target 80%*	▼	Diagnostic waits remain challenged by rising demand and capacity constraints. Recovery schemes focused on additional capacity, vetting and validation are being progressed to support improvement.
Urgent & Emergency Care	% of patients waiting 12 hours or more in the Emergency Department CAVUHB	Apr-26: 7.9% May-26: 7.4% Jun-26: 9.2% De-escalation *Target 7%*	►	UEC remains challenged by rising demand and admissions, although gains are being seen in flow, discharge and length of stay. Planned actions focus on ward flow, frailty, same day emergency care and community alternatives ahead of winter.
	Ambulance handovers > 45 mins	Apr-26 May-26 Jun-26	▲	

		157 | 81 | 173 De-escalation *Target 428*		
Corporate				
Workforce	Sickness absence	Jun-26: 6.09% Cumulative 6.39% Jul-26: 6.23% Cumulative 6.38% Aug-26: 6.10% Cumulative 6.39% *Welsh Gov Target <5.5%*	▼	Sickness absence remains above the 5.5% target, with August at 6.10%. While this continues to present a workforce availability and wellbeing risk, rates are lower than the same period last year, suggesting early impact from attendance and wellbeing actions. Sustained focus is required to reduce absence further.
£ Finance	August Financial position	Variance to Planned Deficit YTD £7.1m Overspent Plan = £36.0m Actual = £43.1m Savings Target Gap £23.0m Savings plan target = £47.6m Savings Identified = £24.6m	▼	The UHB is forecasting an £86.5m deficit and is £7.1m above plan at Month 5. Delivery of additional savings must accelerate to support achievement of the planned deficit target.

Independent Assessment Report

In response to the recommendations set out in the Independent Assessment Report, I intend to use the findings as a catalyst for focused and sustained improvement. The report will inform the redesign of our structures, governance and operating model over the coming months, with clear emphasis on strengthening accountability, clinical engagement and delayering management ensuring the Health Board is fit for purpose for the future.

A central principle of my response will be that quality, safety, performance and financial sustainability must be treated as interdependent, not competing priorities. Improving care first time, reducing avoidable harm, strengthening patient flow and ensuring people are cared for in the most appropriate setting are essential both to better outcomes for patients and to our financial recovery.

Delivering this will require greater discipline in prioritisation, stronger financial grip and clearer accountability for performance. I also want to ensure that operational leaders are properly supported with the analytical workforce and financial capacity needed to lead services effectively and make timely, evidence-based decisions.

Given our current Level 4 escalation status, my immediate focus is on restoring confidence through demonstrable improvement in performance, financial control and governance. While tighter oversight is necessary in the short term, my longer-term intention is to devolve decision-making where accountability, control and assurance are sufficiently mature to support it.

I am committed to working closely with the Chair, the Board, and colleagues in Performance and Improvement within NHS Wales to improve the Health Board's performance, strengthen confidence in our delivery, and build a credible and sustainable route to financial recovery.

Organisational Redesign

Following Board approval in July 2026, work is progressing on the next phase of the Health Board's organisational redesign programme to support delivery of Shaping Our Future Wellbeing, the Clinical Services Plan and long-term financial sustainability. The agreed direction of travel includes transitioning from the current seven Clinical Boards to a three Care Group model, designed to strengthen service integration, enable greater collaboration across clinical pathways, enhance clinical leadership and decision-making, and support more devolved accountability closer to care delivery. Detailed implementation and resource planning is now underway, with continued engagement of staff, clinical leaders, trade unions and partners to ensure the redesign supports both organisational performance and high-quality patient care.

Building relationships externally

Building strong external relationships is an important part of my role as Chief Executive, particularly as we work to improve performance, strengthen confidence and support the Health Board's wider recovery journey. Since taking up post, I have prioritised engagement with key partners across NHS Wales and the wider system, including attending the JCC Strategy Workshop and the NHS Wales Leadership Board. These discussions have provided valuable opportunities to contribute to national strategic priorities, understand the wider system context, and ensure that Cardiff and Vale UHB is actively engaged in shaping and responding to the challenges and opportunities ahead.

Turning Listening into Action

My early engagement has already highlighted several practical issues where staff have identified opportunities to improve the working environment, support services and strengthen delivery. In response, I have requested the following actions be taken forward:

- An estates risk assessment of all community clinical services locations.
- A solution-focused discussion between Estates and Medical Records to address environmental issues.
- A review and acceleration of the move of the District Nursing team from Whitchurch to an improved location.
- Progression of the refurbishment of dementia wards.
- The provision of lockers for Pharmacy colleagues.
- A review of cold drinking water provision across all locations.
- Changes to the Strategic Leadership Team to refine attendance and ensure each meeting has a sharper focus on performance oversight.
- HSDU to host surgeons to improve mutual understanding of each service and strengthen working relationships.
- Unfrozen District Nursing Posts – critical to reducing length of stay in acute hospital beds and supporting community by design.
- Look to secure capital funding to procure another surgical robot and spinal surgery guidance system

So what am I doing next?

- I will continue to listen directly to colleagues through the In Conversation programme, senior clinical forums and regular visibility across services, using this feedback to shape our priorities and how we lead change.
- I will maintain a clear focus on improvement and transformation, including our response to the Independent Assessment, the development of a new operating model and strengthening clinical leadership, culture and accountability.
- I will ensure financial recovery, workforce controls and operational performance are gripped together, balancing delivery and accountability with the need to protect quality and safety.

What I need from colleagues

To make progress, I need colleagues at every level to stay engaged, speak openly, support each other and remain focused on delivery. I also need leaders to be clear about priorities, take ownership of performance, manage resources carefully and create conditions for teams to provide safe, high-quality care.

The months ahead will require pace, discipline and collective effort. We will need to make difficult choices, but we will do so with a clear focus on patients, staff and the long-term sustainability of the Health Board.

My commitment is to lead this work visibly and transparently, to keep listening, and to ensure that the improvements we pursue are meaningful, measurable and felt by the people who use and deliver our services.

For Information

My Chief Executive report includes a summary of action & decision logs from Strategic Leadership Team meetings which can be found in the Supporting Documents folder within the Public Board MS Teams Channel and the Cardiff and Vale UHB website.

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 Click the objective to view more detail		Providing Outstanding Quality Click the objective to view more detail	
Delivering in the Right Places Click the objective to view more detail		Acting for the Future Click the objective to view more detail	

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

Report Title:	Board Assurance Framework				Agenda Item no.	6.4	
Meeting:	Board		Public	X	Meeting Date:	24 Sep 26	
			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 a governance framework that seeks to align the Strategy with the strategic portfolios and the Committees, using risk themes both to set out those matters that could impact upon the delivery of the Health Board's Strategy and also to align the governance framework at the top of the organisation. 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

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

There have been no changes to overall net risk scores.

As the planning process is underway it is timely to draw attention to the way that risk appetite has been agreed and is set out in the document.

There is a risk appetite aligned to each strategic risk:

Strategic Risk	**Appetite**	**Meaning**
Quality	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential reward
Health Equity	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (VFM)
People	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (VFM)
Digital	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential reward
Infrastructure	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (VFM)
Sustainability	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential reward

There are 4 other appetite options presented in the BAF:

Appetite	Meaning
Avoid	Avoidance of risk and uncertainty is a key organisation objective
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)
Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

There are various sources for risk appetite statements. The UK Government's Orange Book does not explicitly define them whereas the above is similar to the matrix that the Good Governance Institute sets out.

What is the point of a risk appetite statement?

In the context of the strategy, it is most simply the Board's willingness to accept risk in pursuit of its objectives. A strategic document of this nature means that there is a value in setting it out and aligning it to the objectives, the portfolios and the Committees, but there is a value in developing risk discussions in a more specific and nuanced way.

How?

The organisation has a lot of concurrent activity:

- IY savings and turnaround;
- de-escalation activity including IA response;
- 26/27 plan delivery and accompanying WG allocated deliverables;
- the development and implementation of a quality management system (QMS);
- the development and implementation of a performance management framework (and the national work on standardising performance reporting);
- the development and implementation of a grip and control plan;
- strategic objective specific activity – People and Culture Plan, Digital Foundations and associated business case, Estates condition survey, risk and rationalisation programmes and so on.

How these are brought together is an ongoing discussion – the standing Board and Committee governance construct as set out by this BAF is an element and the transition of Committees to AAA reporting is a part of establishing the right flow through to the right level of scrutiny. The Integrated Improvement Plan is seeking to bring together 100s of tasks that sit across a number of the above, and the performance management framework is a critical piece of governance architecture in development.

The best application of risk appetite discussions, while cognisant of the strategic position set out here, is more focused and purposeful. The IY financial recovery work will require risk appetite to shape what is an isn't an acceptable decision and will feature in the governance that has been wrapped around it – at CB, SLT, Executive and Committee level.

And in looking forward, it is the 27/28 plan work that needs to address the priorities and so what risk is acceptable to the Board. It is anticipated that this will feature as part of the Board Development discussion on the plan next month.

Recommendation:

The Board is requested to:

- **Review and note** the risk themes regarding the delivery of Strategic Objectives detailed on the attached BAF.
- **Reacquaint** itself with the strategic risk appetite as a framing of the ongoing Plan 27/28 discussion.

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 24 Sep 26

Shaping Our Future Wellbeing

Introduction

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

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

Strategy	Putting People First	Providing Outstanding Quality			Delivering in the Right Places	Acting for the Future
Committee	People and Culture	Quality			Digital and Infrastructure	Finance and Performance
	Audit and Assurance | Charitable Funds | Remuneration and Terms of Service					
Strategic Portfolio	Shaping our People and Culture	Shaping our Population Health and Place based Partnerships	Shaping our Quality, Value and Sustainability	Shaping our Future Clinical Services	Shaping our Future Infrastructure	Shaping our Future Generations
Strategic Risk Theme	People	Quality			Digital	Sustainability
		Health Equity			Infrastructure	

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

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

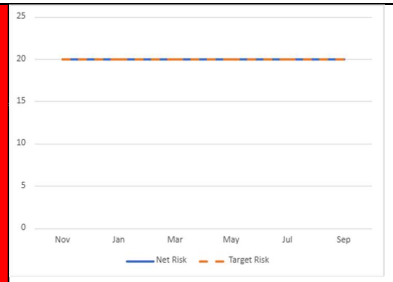
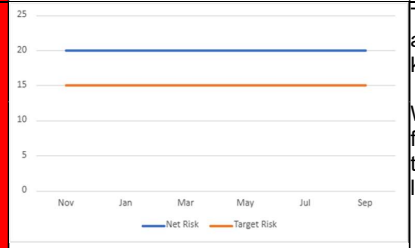
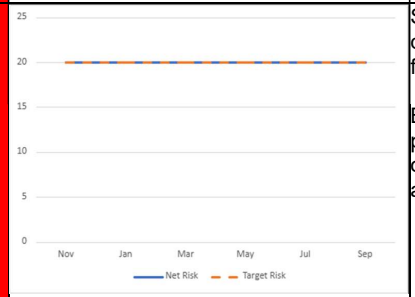
What will prevent Cardiff and Vale University Health Board from delivering its strategy?
If any of the below risk themes cannot be controlled, then the strategic objectives are unlikely to be met.

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 **12**	**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

Shaping Our Future Wellbeing

Strategic Risks – Quality

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

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

Shaping Our Future Wellbeing

Strategic Risks – Quality

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

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

Shaping Our Future Wellbeing

Strategic Risks – Quality

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

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

There is a risk that workforce, digital, capacity and estate constraints, combined with weak escalation and organisational learning, lead to inconsistent and unsafe care, resulting in avoidable harm, poorer patient outcomes, long waits, reduced patient experience and diminished public trust.

Cause	Impact
Workforce Vulnerabilities in our Workforce including availability, retention, culture and leadership can impact on our ability to deliver safe effective timely and patient centred care **Digital Enablers** The absence of a joined up digital patient record and patient management system has resulted in omissions in care and disruption to patient pathways Ability to deliver effective care is impacted by outdated systems related to digital technology, clinical coding 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. The lack of data relating to population health and protected characteristics means that we are unable to effectively measure variation in outcomes. **Capacity and demand** 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. Pressure within the urgent and emergency care pathway is driven by extended length of stay. Opportunities to maximise out of hospital services have not been fully realised. **Environment** The ageing environment is leading to challenges including to disruption to services and Infection prevention and control risks and poor patient experience **Whole Systems approach** Gaps in our clinical governance structure means that risk is not clearly articulated and Escalated and that mitigation is often localised rather than delivered at an organisational level. **Improvement and learning capability** Learning from events is often undertaken at departmental level with infrequent evidence of embedding organisational learning	**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

.		**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.	• 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 • AMaT • Shaping Our Future Quality Excellence

Shaping Our Future Wellbeing

Strategic Risks – Quality

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

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. **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.	
Gaps in Controls	**Gaps in Assurances**
A recent advisory audit of Clinical Governance demonstrated gaps in reporting and escalation The availability of data to support benchmarking and monitoring of performance is limited by poor coding compliance Participation in a number of National Clinical Audits is sub optimal with poor case ascertainment and data quality The availability of data relating to protected characteristics means that measures of variation in outcomes by population is limited. The Development of the Quality management system is underway, but this is a two-year programme to embed this work	The control gaps identified mean that assurance at Committee and Board level is undermined and so the Committee work is being reviewed and redeveloped.

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

Shaping Our Future Wellbeing

Strategic Risks – Quality

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

Actions			
What	**Lead**	**By**	**Update**
Deliver stroke improvement plan to address quality concerns in acute stroke pathway	PB	31/03/27	• 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 25 • Performance is consistent despite operational pressures. Increases in thrombolysis rates, work remains on % in time. Detailed review of thrombectomy undertaken • Stroke summit highlighted improvements in performance for some parts of pathway alongside increased challenges – particularly rehab length of stay. Work ongoing • Stroke Summit 16th June - agreed actions were to continue on all workstreams, review SRC's accommodation and clinical model and facilitate Exec colleagues' conversations with available data in the stroke dashboard.
Develop and deliver improvement plan for cancer and long waiting patients, including a plan to reduce diagnostic waiting times.	PB	31/03/27	• 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. • Q2 performance slightly ahead of trajectory for 104 week waits. • On-track of 450 patients waiting longer than 104 weeks by end of March. • Diagnostic challenges mean improvements will be delivered but not to the level previously expected • End of year position significantly improved for 156 weeks, 104 weeks and 8-week waits • Recurrent demand and capacity mismatches will lead to worsening of position in 26/27 without further investment • Delivering productivity and efficiency opportunities key to mitigating position • Working closely with national colleagues to maximise productivity opportunities, backlog forecast position improved from April 2026. Still expect 104-breaches in challenges specialities.

Strategic Risks – Quality

			• Non-recurrent Welsh Government funding has been provided for in year schemes against some specialities. This funding is less than requested, work underway to re-profile revised 104 end of year position.
Develop and deliver long term proposal for ITU capacity – Strategic Outline Case in production	PB	31/09/26	• 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 • C1 work will completed in December. Planning in place to install updated UPS • C1 work completed. UPS completed. • Detailed request for funding for C3 refurbishment, and indicating plans for subsequent A3, B3 upgrades, will be sent to WG in Q4 • Completion of proposal has been delayed due to capacity pressures, aiming for submission in Q2 26/27 • Programme Business Case will be re-reviewed at Value and Benefits Realisation Group in October.
Deliver the Theatres Together Programme which includes important quality elements such as the WHO checklist and productivity improvements	PB	31/03/2027	• 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 • Progress made across programme with improvements in staff feedback. • A number of capital and estates improvements have been delivered with wider programme in development • Theatre efficiency and utilisation improvements form significant part of future work • Significant positive feedback from staff engagement sessions – indicating embedded ~~imrpvoements~~improvements • Programme continues with an increased focus on productivity, efficiency and best practice
Review, design and improve mental health services which are noted to carry risks to quality	PB/DF	31/03/2027	• External consultancy appointed to support with review of mental health services – work ongoing • Plans for neurodevelopment services undergoing significant scrutiny • 3-year ND waits for children and young people likely to be >450 by March 2026 – working with WG and NHS P&I. • 3-year ND waits reducing for end of life but will increase in 26/27 • Implementation phase of transformation work to begin in 26/27 • Transformation plans developing and being delivered. Consideration of phase 2 opportunities from external support. Focus on out of area placements

Formatted: Font: 10 pt

Formatted: Normal, Indent: Left: 0 cm

Shaping Our Future Wellbeing

Strategic Risks – Quality

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

Length of stay and continuity of care	PB	31/03/2027	• Length of stay programme in place – aiming to deliver, as a minimum, mean peer performance in medicine non-elective by the end of March 2026/27. • Performance and productivity board in place to monitor and drive change
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 • 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 insufficient investment in prevention, worsening socio-economic determinants, inequitable access and poor data limit the Health Board's ability to address inequalities, resulting in widened life expectancy gaps, higher morbidity in deprived populations and increased long-term demand on services.

Cause	Impact
Risk: a lack of investment in prevention • Our organisation aims to shift spending from reactive hospital care towards prevention and proactive care in community settings. However, secondary care continues to receive an increasing share of NHS funding, leaving prevention under-resourced. Addressing this imbalance is essential for our long-term sustainability. • There is currently a lack of capacity to deliver evidence-based interventions at scale to tackle smoking, obesity, vaccination, alcohol, substance use etc. that drive the huge disparities in health outcomes we see across Cardiff and the Vale of Glamorgan. • There is also currently a lack of capacity to undertake more substantial work on the wider determinants of health with partners, such as improving housing, educational attainment and employment. • There is currently a lack of investment in prevention: the Faculty of Public Health recommends 15 public health consultants for a population of 500,000, we employ 5.5 WTE. **Risk: worsening socio-economic determinants of health** Health inequalities are well documented across the UK and arise in multiple ways, including structural issues e.g. income, employment, education and housing and unhealthy behaviours due to the environment, social norms and income levels. Worsening socio-economic determinants in the UK are impacting on health needs and outcomes in general, but particularly for those most vulnerable in our communities.	**Impact: widened life expectancy gaps and higher morbidity in deprived populations** The risks identified above contribute to worse health outcomes and a worsening of the gap in life expectancy and healthy life expectancy between different members of our population. **Impact: increased long-term demand on services** Health inequalities are already estimated to cost £3-4 billion annually in Wales through higher welfare payments, productivity losses, lost taxes, and additional illness. 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 living in more deprived areas compared to those living in the least deprived (Cost of health inequality to the NHS in Wales - Public Health Wales) A lack of investment in prevention will cause an increase in future health service costs associated with health inequities. The 2026 Cost of Smoking in Wales Report highlights the significant costs of smoking - to the NHS, social care, in lost productivity and to the environment. In 2022/23, smoking cost Wales more than £1.56 billion. Nearly one-third of all smoking-related cost (£489.8 million; 31.4%) is concentrated in the most deprived fifth. Prevention funding also needs to be sustainable and planned for the longer-term so that innovative approaches to reducing health inequities, such as through the work of the Cardiff and Vale Health Inclusion Service (CAVHIS), can continue to

Formatted: Indent: Left: 0 cm, First line: 0 cm

Formatted: Space After: 12 pt

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

People living 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. Risk factors interact and multiple aspects of disadvantage come together, increasing the disease burden and widening equity gaps. Moreover, disadvantage experienced in childhood is often compounded and exacerbated through adult life and therefore often passes inter-generationally.

Examples of the impacts of these inequities on health include:

- 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.
- In 2021, in England, the *undiagnosed* diabetes rate was double for those in the bottom Index of Multiple Deprivation quintile compared to the top. This presents a challenge for the NHS in finding those with an unmet need for healthcare.
- 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.
- Smoking is a major contributor to health inequalities; smoking prevalence is typically higher in areas of greatest deprivation and has a significant influence on morbidity and mortality. In Wales in 2020-2022, 14.5% of deaths in adults aged 35+ and living in the most deprived areas of Wales were attributable to smoking, compared to 7.7% of those living in the least deprived areas. In Cardiff and Vale in the same period, 9.8% of all deaths in adults aged 35+ were attributable to smoking, involving 5,573 admissions to hospital.

Risk: inequitable access to services

Access to, or experience of, services, public information or healthcare sites that may be relevant / pertinent to particular health and wellbeing needs, continues to be inequitable, including as a result of discrimination. The 'Inverse Care Law' has been recognised for over 50 years, with those experiencing disadvantage consistently experiencing more challenges in accessing health services. Inequity build on progress made, maximise impact and ensure that achieved gains are not reversed.

~~However~~ Ttaking preventative action on health inequities can reduce premature mortality, reduce social disparities, and reduce the absolute time in ill-health for people in our communities. For example, using a NHS service such as 'Help Me Quit' can increase a person's chance of successfully quitting smoking. ~~However~~, Bby locating 'Help Me Quit' clinics in areas where smoking prevalence and deprivation are highest and delivering clinics on different days and at different times of day, barriers to accessing these services can be further reduced.

This preventative action can in turn reduce the burden on and costs to the Health Board and social care, while enabling our population to be more productive in our working lives. Spending on prevention has 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% lower non-elective admission rates and 10% 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 preventative care closer to home will also support the UHB to fulfil its organisational priorities as described in its Strategy, because they are derived from the changing needs of the population.

Formatted: Normal

Strategic Risks – Health Equity

of access to healthcare continues to be evident in Cardiff and the Vale of Glamorgan. **Risk: limited and poor quality data** Evidence suggests that key population groups with multiple vulnerabilities include: • Some people in 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 However the quantity and quality of data on the health needs, outcomes and experiences of people from these and other disadvantaged groups is highly limited. This impacts on our ability to both understand and mitigate health inequities using evidence-based and effective approaches.	

Formatted: Indent: Left: 0 cm

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.	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 Senior Leadership Team (SLT)

Strategic Risks – Health Equity

- 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.
- 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. The UHB also now has an Equity & Inclusion Manager, together supporting Clinical and Service Boards, including with awareness and training on completing Equality Impact Assessments.

3. Our Strategy and plans

- The refreshed UHB Strategy 'Shaping our Future Wellbeing' shines a light on the issue of equity at the strategic level.
- 'Shaping our Inclusive Culture 2024-2028' is closely aligned with the UHB's Strategy 'Shaping our Future Wellbeing'.
- 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.
- Through our Public Services Board (PSB) and Regional Partnership Board (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 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'.
- An 'Equity, Equality, Experience and Patient Safety' action plan was approved by Board in May 2024, covering 24 initial actions across the Clinical Boards that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. Progress on actions is reported to Quality Committee on a 6-monthly basis (most recent update provided in April 2026). Ongoing review is undertaken to identify outstanding actions and create future actions using the framework.

4. Public Health priorities to reduce health inequalities

The Public Health Team have agreed three immediate priorities that will influence health inequalities (and other work that we will need to bring forward when capacity allows). Work to tackle inequalities needs to take place over prolonged time periods. We 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 (LA) partners, provides governance oversight of this collective action and works to remove any blocks to it. The priority areas are:

- preventing obesity (focus 0-5 years)
- reducing smoking rates

- increasing levels of vaccination (using an outreach model to reduce inequity in uptake). These priority areas are being developed through UHB-wide work, including: • The UHB is continuing to implement and periodically review its strategy to tackle the lower and unequal uptake of vaccination in our most deprived communities, using an intelligence driven approach and involving targeted, behaviourally informed communications and engagement. • The establishment of a Strategic Diabetes Programme Board is a key element to reducing health inequalities. It recognises that diabetes exacerbates health inequalities and aims to reduce the incidence of Type 2 diabetes and eliminate avoidable associated harms. • The UHB has developed a co-ordinated programme of action to reduce smoking in areas/populations where prevalence is highest (often where levels of deprivation are high). It has also taken strong action to introduce enhanced enforcement of no smoking legislation on hospital sites across Cardiff and the Vale of Glamorgan, including introducing innovative approaches that are evidence-based but have not been delivered locally before. This is helping to protect vulnerable people and signpost people to stop smoking support services. **5. ~~Work to support health equity through~~ Ppatient engagement and feedback** The All-Wales People's Experience Framework was launched in April 2025. There are now several methods being used to gather feedback with the aim of ensuring all patients can contribute (available from the Patient Experience SharePoint pages). Training tools and guidance are also now available to support staff in engaging more effectively with patients and service users, helping them gather meaningful feedback about their experiences. These are complemented by feedback-in-focus sessions held across sites to support patients, staff and carers in completing and understanding the many ways we collect feedback, offering support where needed. ~~Translation and Interpretation pages have also been developed in line with the Welsh Government Accessible Standards Framework, launched in September 2025.~~	
Gaps in Controls	**Gaps in Assurances**
There is an ongoing need to improve the routine collection of protected characteristics to support the introduction of new indicators. This will need to be addressed by each Clinical Board.	Monitoring data (e.g. on protected characteristics). A Population Health Management System to reduce inequalities by identifying those at risk. Ability to share information between Health Board teams on patient characteristics.

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

Strategic Risks – Health Equity

Actions			
What	**Lead**	**By**	**Update**
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 with further annual actions 2026/2027	• Across the UHB, work continues to meet targets in the existing Equity, Equality, Experience and Patient Safety 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. The most recent updates on this work were presented to the Quality Committee in April 2026 and the next update on this work will be presented in a further 6 months. • Innovative approaches to help people quit are being trialled, such as the 'Allen Carr Easyway to Stop Smoking' method. ~~In addition, the 'Help Me Quit' community service is working in partnership with local primary care practices and networks to take targeted action in deprived areas to promote smoking cessation services and encourage referrals and uptake amongst high-risk patient groups such as those with chronic respiratory diseases.~~The 'Help Me Quit' team has also begun working with Cardiff People First, trialling an approach to help people with a learning disability quit smoking. • As part of the All-Wales Accessible Communication and Information Standards, the UHB has developed an ~~draft~~ Accessible Communication Policy. This policy has now been signed off by the Board. ~~is now in the process of ratification, ongoing over the coming months.~~ The Patient Experience Team ~~We~~ are also currently working closely with the Professional Standards Nursing Team to develop and audit a tool for clinical teams to use to assess their area's compliance with the all-Wales Accessible Communication and Information Standards. This is currently being piloted in selected areas. ~~British Deaf Association, the D/deaf community and the Wales Interpretation & Translation Service (WITS) to roll out a trial British Sign Language (BSL) interpreter patient self-booking process.~~ • In the Cardiff City and South Primary Care Cluster of Cardiff, focused work has begun to understand barriers to vaccination uptake. A survey was launched in May 2026 translated into five community languages (alongside English and Welsh) and will run until the end of August. It ~~will be~~is being shared via community networks and by health visitors as part of their immunisation conversations. This, alongside targeted engagement, will inform interventions to increase vaccination uptake in an area that consistently has the lowest levels within the Health Board area. Targeted engagement this period has included a stakeholder workshop in Grangetown in July with representatives from the public health team, primary care, health visiting, school nursing and community leaders. This has led to recommendations for action which will inform the refreshed Vaccination Equity Strategic Plan. A follow-up workshop is planned for September. • The Childhood & Teenage Immunisations Strategic Action Plan has been approved by the Strategic Immunisations Group and will be reviewed by the Quality Committee in October~~July~~. Equity is a cross-cutting theme of this. CAVHIS appointed 1.5 WTE Mental Health Practitioners in July 26, providing onsite specialist assessment and support for newly arrived people seeking asylum and refuge. These roles allow care to

Formatted: Font colour: Auto

Strategic Risks – Health Equity

			be given 'closer to home' and are expected to result in reduced crisis presentations and improved outcomes for patients. • Planned actions: • Refresh sections of the Population Needs Assessments or undertake Health Needs Assessments for th population that highlight health inequalities and actions that can be taken to reduce these and share these with appropriate partners (e.g. RPB and PSB) • Refresh the UHB's Vaccination Equity Strategic Plan and embed equity as a cross-cutting theme in strategic action plans to address vaccination uptake in childhood, teenage and adult populations. •
Advocate for more resources for prevention as a percentage of the total health board budget.	Claire Beynon	2026/2027	• Continue to advocate for increased resources for prevention to improve the health and wellbeing of the local population. • Ongoing work on the business plans that would allow full implementation of evidenced based interventions to reduce health inequalities for smoking and obesity, to include time frame for benefits. • Suggest a methodology that supports the collection of data on spend on preventative activities, with a focus on primary prevention.
Improve the routine data collection in relation to equality and inequity across the UHB.	Claire Beynon	2026/2027	• Follow the advice and guidance from the internal audit on data collection on protected characteristics ~~once~~ report ~~is finalised~~. • Request further analyses of aspects of access to health services by Welsh Index of Multiple Deprivation. • Expect Clinical Boards to take responsibility for understanding their data in relation to protected characteristics, and to take positive action in relation to this.

Formatted: Normal

Formatted: Indent: Left: 0.63 cm, No bullets or numbering

Shaping Our Future Wellbeing

Strategic Risks – People

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
People	Shaping our People and Culture	Rachel Gidman	People and Culture	Revised 01/05/26

Risk

There is a risk that gaps in workforce planning, productivity, leadership and culture undermine workforce capability, capacity and engagement, resulting in an inability to maintain safe, affordable, high-quality services and deliver strategic transformation.

Cause	Impact
Domain 1: Workforce Sustainability **a) Workforce supply and capacity (recruitment, retention, skills)** • Workforce planning not aligned to demand and capacity (activity planning). • Variable workforce planning capability and inconsistent use of data to inform decisions. Workforce plans are not consistently aligned to future service models, productivity assumptions and population need, increasing reliance on short-term mitigations. • Limited workforce redesign (continued reliance on traditional models). Limited triangulation of workforce, quality, demand and finance data to identify emerging risks early. • Persistent gaps in critical and specialist roles creating service fragility Governance/compliance pressures (ESR/data quality, establishment control, safer staffing, mandatory training, professional registration, legal compliance) divert capacity Limited alignment between education, training and future workforce requirements **b) Workforce productivity and deployment (rostering, job planning, bank/agency optimisation)** • Lack of a unified E-Rostering system limits productivity and safe redeployment Variation in roster compliance and job planning impacting delivery of agreed KPIs. • Suboptimal temporary staffing controls increase cost and risk **c) Workforce affordability (pay bill, agency, variable pay)** • Over reliance on agency and variable pay • Financial constraints limit recruitment, growth and transformation	**Patient experience and outcomes will deteriorate, including:** • Increased waiting times and delays to treatment • Increased length of stay and delayed discharges • Increased patient safety risk linked to staffing gaps and fatigue • Reduced continuity of care and patient experience **Workforce performance will deteriorate, including:** • Increased sickness absence (**>5.5% target**) • Increased turnover and reduced retention (**>10% turnover**) • Reduced productivity and increased reliance on temporary staffing (< required 30% reduction for agency and 10% for Bank) • Worsening staff engagement and wellbeing (<74% target engagement score) **Financial and operational performance will deteriorate, including:** • Increased agency and variable pay spend • Inefficient workforce deployment impacting service delivery **Organisational sustainability and reputation will be impacted, including:**

Shaping Our Future Wellbeing

Strategic Risks – People

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

d) Sickness absence and wellbeing-related capacity loss • High and/or persistent sickness absence reduces workforce capacity and resilience • Mitigation through temporary staffing increases cost and reduces continuity of care. **Domain 2: Culture, leadership, wellbeing & workforce experience** • Limited integration of workforce, culture, wellbeing and EDI data reduces early identification of risk Absence of clear, organisational leadership and management expectations and standards leads to inconsistent behaviours and accountability. • Variable management capability impacts staff experience, performance and retention. Psychological safety, dignity and respect concerns affect staff wellbeing and willingness to speak up. • Cultural signals are not consistently triangulated to inform proactive intervention. • Wellbeing model is predominantly reactive, with limited preventative interventions • Sustained operational pressure /inefficient systems reduce wellbeing, engagement and increases burnout risk. Inequity in workforce experience and outcomes across staff groups.	• Reduced ability to recruit and retain staff in critical roles • Widening inequalities in workforce experience and outcomes • Reduced staff trust and engagement **Strategic delivery will be compromised:** • Delay or failure to deliver service transformation and organisational priorities

Uncontrolled Risk			
Impact: 5	Likelihood: 4	Gross Risk: 20	Target Risk: 12

Controls	**Assurances**
Overarching: • People & Culture Plan aligned to UHB strategic priorities. • Workforce Planning Training programme in place. • Annual Plan with key deliverables, supported by Clinical Board delivery plans. • Speak up Safely system, SUS/WIC. • Clinical Board/CEF – bank and agency reduction plans • Strategic plans aligned to EDI priorities. • Medical & Dental workforce workplan. • Temporary pay controls in Clinical Boards.	Overarching: **People and Culture Committee** oversight of workforce risks, performance and delivery **Monitoring of People and Culture Plan** deliverables and performance trends (including KPIs) **Annual Plan reporting**, on workforce risks and delivery **External assurance**, including Welsh Government oversight and performance reviews,

Shaping Our Future Wellbeing

Strategic Risks – People

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

• Managing attendance at work policy and training. **Domain 1 Controls: Workforce Sustainability** • Nursing workforce forecasting and safer staffing processes to identify and escalate capacity risks Recruitment, onboarding and retention approaches, including use of workforce data to inform interventions. • Workforce risks incorporated within IMTP and Annual Plan processes Improved education commissioning process. • Bank and agency governance/controls to manage use, authorisation and cost. • Sickness absence case management, OH/EHWS support and return-to-work processes. • Education, training and talent development pathways to support workforce pipeline **Domain 2 Controls: Culture, leadership, wellbeing & workforce experience** **Leadership & Culture** • Leadership development and OD interventions, supporting capability to lead teams effectively under pressure. • Raising Concerns / Speaking Up Safely framework, supporting staff voice and response. **Wellbeing** • Integrated health and wellbeing model (preventative, early intervention, specialist support). Occupational Health and Employee Wellbeing Services **Equality, Inclusion & Workforce Experience** • Strategic Equality Plan, Anti-Racist Action Plan and WRES, • Welsh Language Standards. **Engagement & Insight** • Staff survey and engagement mechanisms. • Wellbeing, Employee Relations and engagement data	**Domain 1 Assurances: Workforce Sustainability** • Workforce reporting (including Nursing Staff in Post) tracking vacancy, supply and capacity risks • Recruitment, retention and workforce experience data, including exit questionnaires and new starter insight . • Workforce planning outputs within Annual Plan and service planning processes. Workforce and financial performance data (including temporary staffing usage and cost) **Domain 2 Assurances: Culture, leadership, wellbeing & workforce experience** **Leadership & Culture Assurance** • Staff Survey and staff engagement data (leadership, psychological safety, dignity and respect). • Employee relations data and themes. • Speak Up / Work in Confidence data. **Wellbeing** • Occupational Health and Employee Wellbeing Service data (demand, access, outcomes) • Sickness absence data (including stress-related absence **Equality & Workforce Experience Assurance** • WRES, Strategic Equality Plan and Anti-Racist Action Plan reporting, • Analysis of differential workforce experience (disciplinary, progression, access to opportunity). **Triangulated Insight** • Increasing triangulation of workforce, culture, wellbeing and EDI data to identify risk and hotspots.

Shaping Our Future Wellbeing

Strategic Risks – People

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

Gaps in Controls	**Gaps in Assurances**
Workforce Sustainability • No consistent, organisation-wide workforce planning framework (standards, tools, governance). • Variable workforce planning capability resulting in reactive decision-making. • Stronger controls for nursing than other staff groups (e.g. medical, AHP, A&C) • Over-reliance on temporary staffing and short-term mitigations. • Sickness absence controls more focused on case management than prevention • Limited integration of digital, automation and role redesign into workforce planning. • External workforce supply constraints (national shortages) increase residual risk. • Sustained operational pressure increases demand for cover, stressing existing controls. • Talent management and succession planning is not consistently defined.	**Workforce Sustainability** • Limited assurance on the quality and use of workforce plans to inform decision-making. • Assurance focused on current-state metrics, rather than future sustainability and modelling. • Inconsistent assurance across staff groups (stronger for nursing than others). • Limited outcome-based assurance on sickness absence reduction. • Limited assurance on effectiveness of actions to reduce reliance on temporary staffing beyond activity/cost monitoring. • Limited visibility of digital and workforce productivity impact.
Domain 2: Culture, leadership, wellbeing & workforce experience **Leadership & Culture** • No agreed organisational leadership and management standards • Inconsistent management capability, particularly in leading teams under sustained pressure and supporting staff wellbeing • No organisational cultural dashboard to monitor risk systematically. **Wellbeing** • Wellbeing model remains predominantly reactive • Increasing demand and complexity within Occupational Health and Employee Wellbeing Services.	**Domain 2: Culture, leadership, wellbeing & workforce experience** **Leadership & Culture** • Limited assurance on leadership and management capability, beyond staff perception measures. • No structured mechanism (e.g. dashboard) to identify emerging cultural risks early. **Insight and Early Warning** • Limited triangulation of workforce, culture, wellbeing and EDI data for early risk identification. • Reliance on developing workforce analytics capability to provide sustainable organisational cultural intelligence and early warning reporting.

Shaping Our Future Wellbeing

Strategic Risks – People

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

• Limited organisational controls to address sickness absence at a structural level. • No organisational Wellbeing Framework. **Workforce Experience, Access & Inclusion** • Inconsistent communication and access to information and support. • Variable awareness of, and access to, wellbeing and support services. • Inconsistent clarity of support pathways for staff and managers. • Inequities in workforce experience and outcomes not consistently addressed.	• **Wellbeing** • Assurance focused on service demand/activity, not preventative impact or outcomes. **Equality & Workforce Experience** • Limited assurance on differential experience and outcomes across staff groups,

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

Actions

What	Lead	By	Update
Agree and publish an organisation-wide Workforce Planning Framework (scope, required inputs/outputs, templates, scenario rules, governance/approvals, annual cycle and escalation), plus additional targeted short training/implementation plan for managers.	Donna Davies	Sept-26	HEIW Workforce Planning methodology has been adopted, supported by their online introductory training. HEIW are sponsoring workforce planning and data analytical training for people & culture leads. Workforce planning is being integrated as part of annual planning process with service and finance.
Medical & Dental workforce deployment, including implementation of a unified E-Rostering system, robust job planning, implementation of the Welsh Resident Doctor Contract (WRDC), etc	Martyn Capel	Aug-276 (phase 21)	WRDC/E-Rostering was presentedation to P&C Committee in July 26. The financial costings are to come back to P&C Committee and Finance & Performance Committee in Sept 26. Phase 2 - an update will be presented to P&C Committee in Sept 27.
Continue to reduce the reliance on temporary workforce through agency and bank reduction & improve monitoring through development of a dashboard.	Lianne Morse	Mar-27	P&C Committee receive updates via Workforce KPI report (bi-monthly) Board receive updates via IPR.

Shaping Our Future Wellbeing

Strategic Risks – People

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

Strengthen leadership accountability and early intervention through a consistent, data-led attendance management and wellbeing approach to sustainably reduce sickness absence.	Katrina Griffiths	Mar-27	P&C Committee receive updates via Workforce KPI report (bi-monthly) Board receive updates via IPR.
Develop and implement organisational leadership and management standards, including defining how capability will be assessed and assured at organisational level in collaboration with HEIW national work.	Claire Whiles	Mar-27	~~Leadership & Management Conference planned for 02/07/26 to engage all leaders.~~ Organisation-wide Leadership and Management Capability Assessment completed, identifying priority capability requirements and informing a targeted improvement programme. Implementation has commenced through management development, the Line Manager Framework, Manager Passport and capability baseline, strengthening future organisational assurance and alignment with emerging HEIW national work.
Develop a proportionate organisational cultural dashboard, drawing on existing data sources, to support early identification and monitoring of cultural risk.	Claire Whiles	Sept~~Aug~~-26 (phase 1)	~~Presented to P&C Committee in May 26, follow up in Sept 26.~~ The Cultural Early Warning System (CEWS) approach was approved by People and Culture Committee in May 2026. Phase 1 development is integrating workforce, wellbeing and staff experience data to support earlier identification of emerging cultural risk, with pilot implementation underway in selected areas.
Redesign and implement an organisational wellbeing model to ensure appropriate balance between preventative, early intervention and specialist support.	Claire Whiles	Nov~~Sept~~- 26	~~Presentation to P&C Committee in July 26. Follow up in Nov 26~~ The case for redesign of the organisational wellbeing model was presented to People and Culture Committee in July 2026. Development is underway to establish a more sustainable model balancing preventative, early intervention and specialist support, with proposals returning to Committee in November 2026.
Transition from WTD% payments to AfC Average payments, aligned to national programme of work to ensure the UHB are legally compliant.	Lianne Morse	Mar-27	National Programme Board to be established, paper going to the National W&OD Directors peer group on 19/06/26. NHSWE currently obtaining legal advice regarding interpretation and impact on terms and conditions.
Organisational readiness for the new Future Workforce Solution (replacement for ESR), prior to implementation	Lianne Morse	Dec-26	NWSSP will commence working with CAV from September~~July/August~~ 2026. Priority is currently with organisations that are early adopters of the system.

Formatted: Line spacing: single
Formatted: Font: (Default) Arial
Formatted: Font: (Default) Arial
Formatted: Line spacing: single
Formatted: Font:
Formatted: Line spacing: single
Formatted: Font: (Default) Arial

Shaping Our Future Wellbeing

Strategic Risks – People

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

Workforce Equality Standards (WES) Report		Claire Whiles	Sept-26	The report was received by the UHB in Aug 26, a meeting with WG is planned for Sept 26. The report will be shared with P&C Committee in Sept 26, seeking Board approval for the 2-3 priorities that need to be prioritised.

Formatted: Font: 10 pt

Formatted: Font: 10 pt

Formatted: Font: 10 pt

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

There is a risk that legacy systems, underinvestment and limited digital capability constrain transformation, resulting in inefficient care delivery, increased cyber risk, missed productivity opportunities and failure to realise strategic ambitions.

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. ○ Work is expected to begin Oct/Nov 2024. ○ This follows positive discussions with WG IIB and NHS CDIO, • An audit by Audit Wales on our approach and plans for Digital Transformation has now been completed. This audit has concluded that CAVUHB has a clear digital ambition and recognises digital as a key enabler of service quality, safety and sustainability. However, there are areas where greater clarity is needed for some Members of the Board on how this ambition will be achieved. Despite this, the Board shows strong ownership of digital transformation and has put governance arrangements in place to highlight key digital risks and priorities. The Audit makes several recommendations, which are detailed below.	• 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.

Shaping Our Future Wellbeing

Strategic Risks – Digital

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

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

Actions			
What	**Lead**	**By**	**Update**
Internal investment case to support the Digital Foundations case approved	Director of DHI	Mar 26	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. The existing Digital Foundations PBC seeks funding from the all Wales major capital budget but has a revenue tail which is currently unfunded. additional work is taking place, including detailed discussion with each Clinical Board, to identify the funding source to enable the PBC to progress through internal CAV UHB governance process – this will likely not happen until the new financial year. May 26: Meeting with WG's Head of Capital, CAV DoF and CAV DoD took place on 13/05/26 to provide update and share summary information in advance of a formal submission if agreed by CAV Board following due governance process. July 26: Capital bids invited by WG specifically to address Estates Backlog and DIgital Maintenance (back-log) costs, resulting in CAV submitting a digital maintenance bid for £7.8m in June 2026. There has been no further update on the consideration of the Digital Foundations PBC and associated year 1 BJCs submitted earlier in the year.
Development of the Digital Programme Business case to support the digital foundations ambitions is underway.	Director of DHI	May 26	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. Nov 25: Further scoping and detailed workshop being held with each Clinical Board during November and December to capture the detail of where savings can be made arising from automation and digital changes which will be used to off-set the revenue shortfall. The DF PBC has been shared with digital team at WG following the Digital presentation made at the November IQPD meeting. The intention is to submit the final case to Board for approval prior to formally submitting to WG for consideration via the Infrastructure Investment Board Jan 26 – additional work to identify the funding source for the associated revenue costs – especially in year 1 of the PBC means that the process will slip into 26/27. Decisions on allocating WG major capital are not expected until well into Qtr 1 26/27. May 26: An updated PBC and Year 1 BJCs have been developed and are in the process of working through the internal governance process having been reviewed by the D&I committee, SLT and Value & Benefits Realisation Group and Capital Management Group, with the case to be considered at the Finance & Performance Committee prior to submission to Board on 28/05/26. July 26: Audit Wales have completed their audit into CAV's Digital Transformation, resulting in 8 specific recommendations: Strengthen strategic delivery and affordability Develop the Board's understanding of Digital Improve assurance over digital and cyber risks Establish a clear approach to AI Build workforce readiness for digital transformation Have clear contingency plan for funding digital transformation Embedding how it works with staff and patients in its digital developments Reporting on digital programme benefits The management response to the above recommendations sets out the actions to be taken, which will be shared in more detail at the D&I committee meeting in August 2026.

Shaping Our Future Wellbeing

Strategic Risks – Infrastructure

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
Infrastructure	Shaping our Future Infrastructure	Exec Dir Finance	Digital and Infrastructure	12 November 2018

Risk

There is a risk that ageing estate, insufficient capital investment and delays in major programmes impair service environments and infrastructure, leading to safety risks, service disruption, poor experience and inability to modernise services.

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 is 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 will be updated following the conclusion of the conditions survey, clinical services plan and the site masterplanning work. • Statutory compliance estates programme in place • 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 2026/27 Capital Plan will be submitted for Board with the Annual plan • 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 is managed within the remit of the Capital Management Group. • Business Case production or delivery is managed through the Capital Management Group/Investment and benefits realisation group . • Welsh Governments stated priorities are Theatres including Vascular/MTC theatres, Haematology including BMT and ITU refurbishment. • Welsh Government has agreed regarding the Shaping Our Future Acute Hospital Programme a series of activities which will support the Health Board to refresh its estates strategy.	• The Health board teams including estates and capital team work with Welsh Government to identify opportunities to improve the estate sustainability and manage any emergent or urgent risks. • The statutory compliance areas are managed and monitored within the Health Board • The Capital Management Group, Senior Leadership Team the Digital and Infrastructure committee and Finance & Performance Committee
Gaps in Controls	**Gaps in Assurances**
• The current annual discretionary capital funding is insufficient to meet all the priorities identified through risk assessment, Annual Plan and Strategic ambitions of the organisation. • further impact the teams and resources available • Traceability of Medical Equipment • The Welsh Government capital funds are insufficient to meet the capital requirement	• the regular statutory compliance surveys remedial works .

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

Shaping Our Future Wellbeing

Strategic Risks – Infrastructure

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

Actions			
What	**Lead**	**By**	**Update**
Infrastructure risk management	Geoff Walsh	Q2	The Vision document is in progress although it is now anticipated that it will be finalised and presented to Board for approval in Q3 26/27 to submit to Welsh Government for the future of critical services at UHW to include EU , ITU, Diagnostics, theatres and inpatient surgical beds. Review of the condition survey data to bring forward a plan to address the highest risk elements identified in the report to inform discussions with the D&I committee and WG for funding Q3 2026/27 BMT/Haematology Strategic Outline Case submitted to WG in June 2026 Response to JACIE following inspection report has been returned PBC for ITU refurbishment to be considered by Board in Q2 2026/27 Theatres refurbishment no progress on the Business Case Development. However, funding for 2nd phase of refurbishment included in Discretionary capital programme. Ophthalmology theatres business case Project team established, and design team appointed. Clinical Board to re-visit project mandate. Commencement of the Park View (Ely) health and wellbeing centre infrastructure project in Q2 26/27. Delay in agreeing construction contract clauses, now resolved. Capital management group to oversee a review of medical equipment risk across the assets and support the development of a management plan Q4 26/27 Work with Welsh Government to highlight and mitigate risks and opportunities to manage infrastructure issues in a proactive and sustainable way.
Estate utilisation a programme of decommission, disposal or demolition is undertaken to minimise the estate and infrastructure which the Health Board needs to maintain.	Geoff Walsh	As per individual actions	Decommission priorities – Denbeigh and Carmarthen house have been vacated, and planning permission is being sought for their demolition. Tenders to be issued and funding support to be sought from WG. Anticipated to commence demolition in Q3 26/27 Demolition of Brecknock House to be completed in August 2026. Demolition of Sports and Social Club is practically complete. Disposal plans – Rookwood the UHB continue to work with the successful bidder to exchange contarct for conditional sale . However, there remain some contractual clauses to be agreed, completion now anticipated in Q2 2026/27 Roath Clinic and Fairwater Road sites to be declared surplus in Q2 2026

Strategic Risks – Infrastructure

			Clinical service plans are being developed for the future of the ALAS and other Rookwood legacy services as well as Treforest. These are expected to be in place with a site solution by Q4 26/27 Education and clinical service plans are being developed with Cardiff University to develop a future model of delivery for dental education, training and service provision. Q3 26/27 Estates planning around the Dental Hospital will be undertaken in light of the future model. From Q4 26/27. Decommissioning of the Tenovus building in conjunction with Cardiff University
Condition Survey	Geoff Walsh	Nov 26	Develop a management and action plan for the results of the condition survey in two parts, firstly the highest risk issues (Category D & Dx) and then for all other issues identified in the survey. Highest risk management plan to be approved in Q3 26/27. Whole report management plan to be developed in following 9 months and used to inform the 27/28 capital programme for Welsh Government and the Health Board.

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

There is a risk that persistent financial pressures and limited progress on service redesign and decarbonisation undermine long-term sustainability, resulting in continued external intervention, investment paralysis, failure to meet statutory duties and weakened organisational resilience.

Cause	Impact
Decarbonisation and Climate	
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.	Interim findings from the 2026 Heatwave Staff Impact Survey demonstrate the growing impact of extreme heat on workforce wellbeing, productivity, and healthcare delivery. A total of **91.8% of respondents reported poor comfort levels**, **88.5% reported reduced productivity**, and **35.4% experienced heat-related illness** during heatwave conditions. Among clinical respondents, **43% reported increased patient footfall** and **42.5% reported increased patient length of stay** during periods of extreme heat. Combined with climate projections indicating more frequent and severe heatwaves, these findings emphasise the need for accelerated adaptation measures to protect staff, patients, and service resilience. Both of the above factors present a financial risk.
In 2024-25 the UHB's emissions 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. CAV UHB does not have a line of sight to achieve the 40% reduction in directly controlled emissions required by the strategy by 2027 nor the 34% emission by 2030. (from a 18/19 baseline).
Currently, UHB has undertaken an initial climate risk assessment however a comprehensive assessment of current and future climate risks is yet to be conducted.	This renders UHB vulnerable to unidentified climate risks that have a direct impact on healthcare delivery and its financial situation.

Strategic Risks – Sustainability

CAV UHB has limited resource for Sustainability and Climate response.	This will impact on embedding sustainability and building climate response.
Finance	
The conditions required to stabilise the financial position are not yet in place. The organisation does not currently have a sustainable medium-term service/financial plan, and recurrent cost growth continues to exceed available resources. The Health Board does have a model demonstrating a five-year financial sustainability trajectory. It illustrates the potential scale of improvement that could be achieved through service redesign, productivity gains, workforce optimisation and better alignment of capacity with need. However, delivery depends on significant assumptions and enabling actions that are not yet fully developed. Achieving the trajectory would require detailed service and workforce plans, quantified savings schemes, strong programme management and effective governance. As such, it should be viewed as an indication of what may be achievable over time rather than a confirmed route to financial sustainability. Planned deficit of £86.5m in 2026/27 with no identified recurrent route to balance. Recurrent cost growth (pay, workforce, drugs, CHC, demand pressures) outpacing allocation uplift. Limited progress to stop, reduce, or redesign low-value services. High reliance on non-recurrent mitigations as part of savings plans. Growth in unfunded operational commitments. Underdeveloped internal commissioning and weak demand and cost control. Variable financial delivery and accountability across Clinical Boards. Planning cycles not grounded in realistic workforce, activity or cost parameters.	It is unlikely that the continuation of this situation will enable the delivery of the Health Board's objectives or meet Welsh Government expectations. The HB will need to demonstrate strengthened financial grip, consistent decision-making, and alignment between performance, workforce and resource allocation to de-escalate from targeted intervention. The collective impact may be: Breach of statutory financial duty. Continued or escalated NHS Wales intervention. Inability to invest in service redesign, digital, estates or workforce. Requirement for short-term corrective action with potential impact on quality and performance. Reduced flexibility and organisational resilience. Loss of credibility with Welsh Government. Inability to deliver the Health Board's strategy.

Shaping Our Future Wellbeing

Strategic Risks – Sustainability

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

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

Controls	Assurances
Decarbonisation and Climate	
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. The Welsh Government has made it mandatory to report qualitatively on progress regarding climate adaptation. A Working group has been established to identify pathways for climate risk assessment and climate adaptation pathways.	Climate Response plan is under development and will be overseen by Finance and performance committee First Iteration of CAV UHB Climate Risk Assessment has been undertaken and a Climate Adaptation plan is under development. The identified risks will be uploaded in AMaT. Successful in outline stage of the NIHR-funded HASTE research bid with the Institute of Occupational Medicine, Met Office and UKHSA. This is a research study to understand and design adaptation approaches for heat impacts on health care delivery.
Finance	
Scheme of Delegation and financial governance framework for expenditure approval. Annual Operational Plan aligned to savings requirements and control totals. Savings Program monitoring through: – Senior Leadership Team – Monthly Executive performance reviews / Finance deep dives – CEO-chaired Financial Summits Finance Business Partnering providing forecasting, reporting and corrective action support.	Monthly financial reports and savings delivery updates to the Finance & Performance Committee. Board receives monthly Integrated Performance Report including financial risk assessment. Internal audit provides assurance on the adequacy of financial systems and controls. Welsh Government oversight through Targeted Intervention with regular feedback.

Strategic Risks – Sustainability

Monthly Finance & Performance Committee scrutiny. Internal audit reviews of financial controls, planning and budget management. Workforce controls and recruitment approval processes aligned to financial plan compliance.	Forecasts and financial deep-dives reviewed by SLT and Management Executive.
Gaps in Controls	**Gaps in Assurances**
Decarbonisation and Climate	
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 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.
Finance	
No approved medium-term financial strategy addressing the recurrent deficit. No formal decommissioning framework for low-value or unaffordable services. Internal commissioning and demand management not sufficiently developed. Structural savings pipeline incomplete and over-reliant on non-recurrent measures. Weak enforcement of accountability for non-delivery of financial targets. Decision-making not consistently aligned with affordability constraints.	No independent validation of savings assumptions or deliverability. Insufficient triangulation of financial, workforce, activity and quality data. Improving but limited benefits-realisation reporting for previous investments.

Strategic Risks – Sustainability

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

Actions			
What	**Lead**	**By**	**Update**
Procure consultant programme management and turnaround capability to increase pace on the IY savings plan	-A Gough	-Sep 26	-PWC awarded 12-week contract and in situ

Report Title:	Finance & Performance – Chair's Report				Agenda Item no.	6.5.1
Meeting:	Board		Public	x	Meeting Date:	16.09.2026
			Private			
Status *(please tick one only):*	Assurance	x	Approval	x	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 16th September 2026.

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

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

The Committee considered the following key matters and provides the Board with assurance on the scrutiny undertaken:

Month 5 Financial Position
The following points were highlighted under the Financial Position for Month 5:
The Health Board reported a year-to-date deficit of £43.1m, against a planned deficit of £36.1m, representing an adverse variance of £7.1m. The principal driver was a £9.6m shortfall against planned savings, partly offset by a £2.5m operational surplus.

The submitted plan remains an £86.5m deficit for 2026/27. The current forecast of £102.5m requires a reduction of approximately £15m, equating to an average monthly run-rate reduction of around £2.5m over the remaining six months. The Committee noted that the £86.5m position remains materially at risk and has not been de-risked.

Green and amber savings schemes totalling £24.6m were reported as delivering at full value. However, a significant gap remains against the £42.5m core savings target. Recurrent savings of £19.3m have been identified, leaving a recurrent gap of £23.2m.

The Committee received assurance that revised turnaround governance, supported by PwC, would strengthen accountability, grip and control. Quality Impact Assessments will be central to ensuring urgent financial actions do not adversely affect patient safety.

The Health Board closed August with a £6.5m cash surplus, remained above the 95% public sector payment target at 96.4%, and reported an approved capital resource limit of £46.8m.

Operational Performance
The following points were highlighted under the Operational Performance item:
Continuing urgent and emergency care pressures were noted following the June heatwave. Six pilot wards are implementing improved ward processes, earlier decision-making and active board rounds to support flow and discharge.

Delayed pathways of care increased to 177 in August, above the de-escalation threshold of 128. However, average delay reduced from 48 to 42 days, overall length of stay reduced by 0.67 days, and beds lost reduced by approximately 2,500 compared with the previous year.

Clinical coding performance improved from 36.2% of patients coded within 30 days in May 2025 to 84.5%. Single Cancer Pathway compliance improved to 64% in July.

The planned care position remains challenged. The Health Board requested £14m to support a year-end trajectory of 309 patients waiting over 104 weeks, but the allocation remained unclear.

Outpatient actions include overbooking clinics with did-not-attend rates above 5%, potentially providing an additional 7,000 appointments by year end, and moving 17,000 delayed follow-up patients to a see-on-symptoms pathway.

Out-of-area mental health placements reduced from almost 30 at the previous meeting to **seven on 16 September 2026**, exceeding the trajectory of 20.

Diagnostics Deep Dive
The following points were highlighted under the Diagnostics Deep Dive item:
Significant growth was reported in urgent and cancer diagnostic demand, including CT cancer demand of 34.9%, CT urgent demand of 37%, MRI cancer demand of 34% and MRI urgent demand of 75%.

Workforce and infrastructure constraints were highlighted across endoscopy, echocardiography, ultrasound, CT and MRI.

Without mitigation, approximately **17,500 patients** were forecast to wait over eight weeks by year end. Current actions were forecast to reduce this to approximately 3,500.

A costed, sustainable diagnostic plan is expected to return by the end of Quarter 3.

The Committee endorsed the integrated diagnostic recovery programme and supported monthly assurance reporting through the Productivity and Efficiency Board.

Grip and Control Action Plan
The following points were highlighted under the Grip & Control Action Plan item:
The assessment confirmed that a substantial financial control framework exists, but controls are not applied, evidenced or followed through consistently.

The Committee endorsed the development of a consolidated grip and control improvement plan within the Integrated Improvement Plan.

Relevant Executive Directors and operational leads will be accountable for delivery, timescales and completion evidence.

The Committee requested clear read-across to other committees, particularly People and Culture, where workforce and temporary staffing controls require detailed assurance.

Other Matters

- The UEC Hospital Flow and Discharge paper was deferred to the October meeting because it was not received in time. A verbal update was provided concerning work across six pilot wards.
- The Committee received and noted the monthly monitoring returns for months 3 and 4.
- There were no items for approval or ratification.

The committee received and noted the monthly monitoring return for month 3 & 4.

Recommendation:

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:	Quality Committee – Chairs Report			Agenda Item no.		6.5.2
Meeting:	Board		Public	X	Meeting Date:	24.09.26
			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 28th July 2026.

The papers, draft minutes and recording for this meeting, outlining all of the detail on the below items, can be found on the Cardiff and Vale UHB website linked 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.

Clinical Board Highlight Reports: the Committee was advised that the newly piloted AAA reports had been reviewed following publication and, whilst they demonstrated significant improvement in activity across the organisation, they did not provide the level of assurance expected for Public Committee scrutiny. Following discussion with the Chair, it was agreed to withdraw the reports for this cycle to allow further work with Clinical Boards to strengthen the quality and consistency of reporting.

Clinical Safety Group Highlight Report: - The Committee was presented with the Clinical Safety Group (CSG) Highlight Report which provided assurance on the continued development of the Group's role in overseeing existing and emerging clinical risks and supporting a whole-system approach to risk management.

The Committee noted progress in establishing a rolling programme of assurance presentations from Clinical Governance Groups (CGGs), including assurance from the Medicines Safety Group (MSG) on regulatory compliance, opioid safety, critical medicines administration, Clinical Board engagement and the development of wider medicines safety indicators. Updates were also received on patient safety work relating to penicillin allergy recording and the standardisation of adult breathing systems, alongside ongoing work to strengthen Clinical Board risk reporting, shared learning and engagement with the CSG using Clinical Board Assurance Reports.

The role of the CSG in providing oversight of clinical risk, quality and assurance was emphasised. Work was underway to strengthen the group's governance arrangements. The CSG oversaw several specialist governance groups responsible for managing significant clinical risks across the organisation.

The Committee suggested reviewing the schedule of the CSG meetings to align better with the Quality Committee.

Clinical Effectiveness Committee Highlight Report: - the Committee were presented with the report which provided assurance on the Clinical Effectiveness Committee's (CEC) oversight of national clinical audit participation and improvement actions, noting positive audit outcomes in several areas alongside concerns regarding low participation and incomplete data submission in others.

The Committee also noted improvement work in response to paediatric diabetes audit findings, ongoing workforce and capacity challenges, and recurring inpatient diabetes safety concerns. A key theme was the need to strengthen Clinical Board engagement, accountability and oversight of audit findings, data quality and improvement planning, with a revised approach being developed for Clinical Boards to present their improvement plans to CEC for greater assurance on delivery, risk management and outcomes.

Annual Reports: Annual Quality Report 2025/26: - The Committee noted that the Annual Quality Report fulfilled the UHB's Duty of Quality requirements by providing an overview of the quality of care delivered, improvement activity underway, and performance across the six quality domains and six quality enablers.

Regulation 28 Prevention of Future Deaths Report –Health Board Response and Assurance Arrangements: - the Committee was presented with the report and the following was noted:

- A Coroner's Regulation 28 report issued to CAVUHB, Cwm Taf Morgannwg (CTMUHB), and Welsh Government (WG), highlighted concerns regarding delays in recognising and escalating a suspected bile duct injury for specialist referral to CAVUHB as the tertiary centre. The coroner identified a lack of clear referral and escalation protocols, leading to delays in specialist advice and transfer.
- In response, actions had been taken to reinforce consultant-to-consultant escalation processes, remind organisations of existing urgent referral arrangements, and develop a formal regional referral framework with defined triggers, timescales and transfer expectations.
- Further work is underway to strengthen assurance, implementation and compliance monitoring, recognising the importance of timely referral in these rare but high-risk cases.

The Committee were assured that significant work had been undertaken to strengthen the referral pathway and governance arrangements, with a formal case-by-case referral and approval process now in place. Whilst the absence of a formally commissioned service remained a concern and further improvements were required, clearer processes, improved oversight and senior clinical leadership involvement had addressed many of the previously identified issues, with similar arrangements being developed for other non-commissioned specialist pathways.

Board Assurance Framework (BAF): - The Committee received the Board Assurance Framework (BAF) for awareness.

Shaping our Population Health and Place-Based Partnerships: -

Public Health Work 6 Month Update (including Targeted Intervention Indicators)*:* - the report, which outlined progress against the UHB's population health strategy, was presented to the Committee, and the following was highlighted:

- The team had prioritised three key areas: reducing smoking, increasing vaccination uptake, and tackling obesity.
- Performance against WG escalation targets showed improvement in vaccination rates. The gap between CAV and the Welsh average for childhood vaccinations by age five reduced from 4.8% to 2.5%, whilst the gap for HPV uptake by age 15 reduced from 5.2% to 0.6%
- Smoking cessation activity had increased over the last six quarters, with more referrals generated through strengthened work with primary and secondary care, despite no additional resources. However, achieving the increased WG target for smoking cessation was expected to be challenging.
- The report highlighted a continued focus on reducing health inequalities through targeted preventative programmes, with services increasingly delivered through outreach and community-based models in areas of greatest need.

The Committee discussed the need to maximise the wider workforce's role in delivering brief health improvement advice, recognising the limited capacity available for *Making Every Contact Count* training and the continued importance of specialist smoking cessation services such as *Help Me Quit.* Assurance was provided that work was underway across primary and secondary care, local authorities, the third sector and other community partners to increase referrals, strengthen uptake and embed smoking cessation support within future lung cancer screening arrangements, with partnership working identified as essential to maximising impact despite constrained resources.

The Committee noted that work through the Good Food and Movement Plan was being progressed through established partnership governance arrangements to address inequalities in access to physical activity opportunities. Assurance was provided that a completed facilities audit had identified gaps in provision,

would inform local authority planning, and had been recognised nationally as good practice with potential for wider adoption across Wales.

No-smoking and Smoke-Free Environment Policy Compliance at Cardiff & Vale Hospital Site: - the report was presented to the Committee, and the following was highlighted:

- Despite legislation prohibiting smoking on hospital sites since 2021, smoking remained a persistent compliance issue and source of complaints; assurance was provided that measures including enhanced signage, awareness campaigns, staff engagement and a six-month educational phase had been implemented to inform the next stage of the programme.
- Over 1,300 interactions with smokers had taken place during the educational phase, demonstrating ongoing compliance challenges across all groups, including staff, but also providing significant opportunities to offer advice and refer individuals to smoking cessation support.
- Key next steps included strengthening staff compliance and management processes, improving hospital environments, embedding nicotine dependence pathways, enhancing training and communications, and progressing cross-organisational action to support improved compliance.

The Committee noted that the smoking patrols had provided valuable learning and engagement opportunities, including monitoring compliance and supporting referrals to smoking cessation services, while recognising that progression to enforcement would require local authority support, sustainable funding and strengthened UHB policies and procedures.

The advice within the report that enforcement action could be subject to challenge if appropriate systems and controls were not in place was challenged by members of the Committee. Whilst acknowledging the funding and resource challenges discussed, it was suggested that the UHB may be able to take a more robust approach should a suitable route to reinstating enforcement be identified.

The Committee noted that work was ongoing with the People Services to develop a more formal and standardised procedure for line managers, responding to the recommendations within the Shared Regulatory Services (SRS) report. Additionally, the team was exploring ways to engage staff regularly to understand the barriers to compliance, identify opportunities for improvement, and measure progress over time. It was suggested that any formal guidance should clearly articulate the potential use of disciplinary processes where staff fail to comply.

Shaping our Quality, Value & Sustainability: - *no items.*

Shaping our Future Clinical Services:

Cardiology Review Update: - the Committee were presented with the following update:

- Of the approximately 70 recommendations, 30 had been completed and 32 were in progress, with further work underway to strengthen timescales and accountability.
- Positive progress included General Medical Council (GMC) de-escalation of concerns regarding resident doctors, strengthened clinical and operational leadership, improved service resilience, and development of a QMS.
- Whilst the service had moved from recovery to stabilisation, it was recognised that embedding the cultural and behavioural changes required would be a longer-term programme.
- Priority areas included completing demand and capacity modelling, advancing service redesign, and further embedding quality improvement and collaborative working practices.

The Committee were informed that some actions had been slower to commence because priority had been given to embedding the foundational cultural changes within the Directorate.

JACIE Inspection update: - The Committee were presented with the report and the following summary:

- The JACIE accreditation review identified 87 areas of non-compliance from over 2300 assessments. Remedial actions had been implemented and submitted to JACIE within the required timeframe, with 336 of 340 actions completed (98.8%). the four remaining actions related to partial compliance and were not considered material, although further work was ongoing.
- Good progress had been made in addressing key risks, including workforce planning, estates developments, governance arrangements and quality management process. Enhanced oversight

and reporting mechanisms had been established, and plans for the haematology day unit and inpatient facility redevelopment continue to progress.

- The organisation awaited JACIE's assessment of the submitted evidence and remained in a period of uncertainty regarding accreditation. Potential mitigations had been discussed with commissioners should accreditation not be maintained, although significant operational, workforce, financial and patient impact challenges remained. The associated risks remained rated as high, pending a formal decision from JACIE, which was expected later in the year.

The Committee discussed that it would be a significant step for JACIE to withdraw accreditation outright. A more likely outcome may be a further deferral to allow consideration of the WG business case, workforce investment proposals, and progress with inpatient facility developments.

The Committee noted that even if accreditation was deferred, concerns regarding the suitability of the current facilities would remain.

Policies for Approval: - UHB 597 - Accessible Standards and Communication Policy: - the policy was approved by the Committee.

Any Other Business: - *no other business was raised.*

Appendices:

None.

Recommendation:

The Board is requested to:

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

Link to Strategic Objectives of Shaping our Future Wellbeing:

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?

Y		N	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.	6.5.3	
Meeting:	Board		Public	x	Meeting Date:	24.09.2026	
			Private				
Status *(please tick one only):*	Assurance	x	Approval	x	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 Digital & Infrastructure Committee meeting held on 04.08.2026.

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

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.

The Committee considered the following key matters and provides the Board with assurance on the scrutiny undertaken:

Infrastructure, Estates Risks and Board Assurance Framework
The following points were highlighted under the Infrastructure, Estates Risks and Board Assurance Framework:
The Committee reviewed the Capital and Estates risk position, comprising 426 risks, of which 63 were rated high and eight scored 25 or above. The Committee received assurance that the highest risks were being actively managed but requested clearer future reporting on mitigations and associated residual risks.

Asbestos within the UHW boiler house remained a significant risk, with an estimated remediation cost of £1m to £1.6m. Tendering and engagement with Welsh Government would progress in parallel, with the Capital Management Group considering adjustments to discretionary capital if external funding was not secured.

The Committee noted that the condition survey, risk register, Board Assurance Framework, estate rationalisation and longer-term UHW redevelopment plans must be aligned to support prioritisation and investment decisions. Detailed condition survey findings will return to the Committee in Quarter 3.

The Committee noted progress with the JACIE Strategic Outline Case and the ongoing rationalisation of poor-condition or underused estate. The availability of capital funding across NHS Wales continued to affect the Health Board's ability to reduce backlog maintenance and increased its risk profile.

Operation POET
The following points were highlighted under the Operation POET item:
The Committee welcomed the progress and increased maturity of Operation POET. Preparatory testing had identified progressively lower-risk issues ahead of the September UHW exercise.

Single points of failure in key clinical areas had reduced significantly. The principal remaining concern was the 11kV generator, with plans being progressed for a second generator to provide additional resilience.

Health and Safety
The following points were highlighted under the Health & Safety item:
The Committee received the Health and Safety Annual Report and took assurance from progress during the reporting period.

The Health and Safety Culture Plan was reported as 89% complete, while fire training compliance remained an area requiring improvement, with a target of more than 85% for the following year.

Fourteen fire events were recorded in the previous financial year. Current-year incidents had been managed and procedural improvements introduced.

Actions arising from South Wales Fire and Rescue Service visits were being managed with regulatory-level oversight.

The Committee requested a future deep dive on violence prevention and violent warning marker activity, reflecting the impact on staff and the reported increase in incidents and criminal justice outcomes.

Digital Roadmap and Work Programme
The following points were highlighted under the Digital Roadmap & Work Programme updated:
The Digital Foundations Programme business case had been approved by the Board and submitted to Welsh Government.

The Committee noted that the current system could not meet Welsh Emergency Care Data Set requirements and that the proposed software solution formed part of the business case, with alternative funding options under consideration.

The Committee noted the successful go-live of the RISP radiology system and the planned LIMS blood sciences deployment during the week commencing 21 September 2026.

Audit Wales recommendations highlighted the need for stronger Clinical Board accountability, improved technical controls, digital skills development and assurance reporting.

The Committee requested that the Audit Wales recommendations be integrated routinely into the digital work programme and supporting papers.

A Benefits Tracking Board was being established to monitor return on investment and the impact of digital programmes.

The Committee requested greater Clinical Board ownership of digitally enabled service transformation and clearer assurance on the implications, risks and requirements of national digital programmes.

Artificial intelligence will be incorporated into the wider digital plan rather than developed as a separate strategy, with principles and controls being considered alongside Welsh Government and NHS Wales partners.

Corporate Digital Risk Register
The following points were highlighted under the Corporate Digital Risk Register:
Cyber remained the highest-rated digital risk, with further detail considered in private session.

Other amber risks included resource capacity, data quality, clinical records and potential non-compliance with data protection legislation.

Further work was required to align the Digital Risk Register with the Board Assurance Framework and Estates risks.

The register was being maintained as a live document, with a comprehensive cross-referenced position expected by the end of the calendar year and a progress update potentially available in November.

Information Governance and Data Compliance
The following points were highlighted under the Information Governance and Data Compliance item:

The Committee noted 147 information governance incidents during the quarter, of which two required notification to the Information Commissioner's Office.

Freedom of Information compliance had reduced to 76%, with 106 overdue requests.

Information governance training compliance had increased to 77%, while health-record access request compliance was reported at 76%.

Additional capacity was identified as necessary to improve Freedom of Information performance.

The Committee requested that the Freedom of Information disclosure log be updated, including its Welsh-language content and accessibility.

Medical Records
The following points were highlighted under the Medical Records item:

A new standard operating procedure had been implemented for scanned clinical information triage documentation, removing the need to retain duplicate paper copies where reliable digital records were available.

The Committee raised concerns about duplication between digital and paper records and the working environment of the Medical Records team.

Although previous water ingress issues had been resolved, the location remained below ground with limited natural light and ventilation.
A fuller report will return to the next Committee covering short and long-term digitalisation plans, the condition of the estate, and consideration of regional or joint working to support a sustainable records solution.

Regulatory and Other Matters
The following points were highlighted:

- The Committee noted that most food outlets were rated four or five. Bwyd Glas had reduced from four to three because of a structural door issue, which had been rectified.
- All required actions from the Welsh Water inspection on 9 July had been completed, and the latest Natural Resources Wales inspection reported a high level of compliance.
- The Committee also noted the Digital Directors Peer Group minutes and Authorising Engineers reports for ventilation and medical gas pipeline systems.
- There were no substantive items for approval or ratification.

Poli

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

1. Putting People First	x	2. Providing Outstanding Quality	x
3. Delivering in the Right Places	x	4. 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:	Audit & Assurance Committee Chairs Report				Agenda Item No:	6.5.4	
Meeting:	Board		Public	x	Meeting Date:	24.09.2026	
			Private				
Status:	Assurance	x	Approval		Information/Noting		
Lead Executive Title:	Director of Corporate Governance						
Report Author Title:	Senior 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 Audit & Assurance Committee meeting held on 1st September 2026.

The papers for this meeting, outlining all of the detail on the below items, as well as a recording of the meeting can be found on the Cardiff and Vale UHB website.

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

INTERNAL AUDIT PROGRESS REPORT:

The Committee considered the findings and conclusions arising from the individual audit reviews completed during the reporting period.

Three reports which had received Limited or Unsatisfactory Assurance were highlighted:

Flexible Working Arrangements: Limited Assurance was provided, with four high-priority and three medium-priority findings. The audit identified inconsistent completion, approval and retention of flexible-working documentation; incomplete recording of arrangements on ESR; requests remaining without an outcome or beyond policy timescales; and annual leave and bank holidays not always being recorded against employees' actual working patterns.
A multidisciplinary Task and Finish Group has been established, with Clinical Boards required to validate and formally document relevant working arrangements. Completion of the identified improvement work is targeted for 31 October 2026. An update on progress, including how the effectiveness of training and changes in management practice will be assessed, will be provided to the next Committee meeting.

Reducing Health Inequalities: Unsatisfactory Assurance was provided, with five high-priority and one medium-priority finding. Fundamental weaknesses were identified in the governance, quality and use of ethnicity data. The Health Board was unable to demonstrate effectively how this information was being used to identify and reduce health inequalities. Actions have been allocated across the relevant Executive portfolios, and the Committee emphasised the need for urgent, collective organisational action. Further consideration will be given to progress through the Quality Committee, with a future follow-up review expected to provide assurance that the position has improved.

Follow-Ups Not Booked: Limited Assurance was provided, with four high-priority and two medium-priority findings. Although systems and processes were in place, these were not operating consistently or effectively. Audit testing found significant inaccuracies within follow-up datasets, with 84% of sampled pathways assessed as invalid, 11% containing data-quality issues and only 5% representing genuine Follow-Ups Not Booked. A revised Health Board-wide Standard Operating Procedure is being tested, with the intention that this will be embedded by the end of October 2026. Weekly operational and Executive oversight arrangements have been introduced, alongside work to validate the existing backlog, improve clinic outcomes and increase outpatient capacity. The

Committee highlighted the need to manage the patient-safety and health-inequality risks associated with contacting patients digitally and removing patients from follow-up lists.

The Committee also considered the following completed audits:

- Leadership and Management Training and Development: Reasonable Assurance.
- Five Steps of Safer Surgery: Reasonable Assurance overall, although the audit objective relating to day-to-day compliance received Limited Assurance and included two high-priority findings.
- Medicines Management: Reasonable Assurance.
- Local and Shadow IT Systems: Reasonable Assurance overall, although this was described as being at the lower end of Reasonable Assurance, with several high-priority findings and one audit objective receiving Limited Assurance.
- Space Utilisation: Advisory Review.
- Speaking Up Safely: Reasonable Assurance.
- Purchasing of Stock and Equipment within the ALAS Service: Reasonable Assurance.

The Committee expressed concern regarding the findings relating to the Five Steps of Safer Surgery, particularly where action target dates had passed. Progress against these actions will be followed up with the Surgery Clinical Board and reported through the AAA report to the Quality Committee.

The risks associated with local and shadow IT systems, including information governance, cyber security and procurement, will continue to require oversight through the Digital and Infrastructure Committee.

Delivery of the 2026/27 Internal Audit Plan remained at an early stage. The revised plan comprised 40 audits, with two audits at final-report stage, one issued in draft, seven in progress and ten at the planning stage. The Committee approved adjustments to the plan, including the removal of three audits and the addition of seven audits.

INTERNAL AUDIT THEMATIC REVIEW:
The Committee received a thematic analysis of over 190 Internal Audit reviews undertaken for the Health Board during the previous six years. While most audits had received Reasonable Assurance and the Health Board's overall position was broadly consistent with the All-Wales average, there had been a slight increase in Limited Assurance outcomes and a reduction in Substantial Assurance reports.

The areas with the highest levels of Limited Assurance were Workforce Management, Operational Services, Information Governance and Clinical Governance. The analysis covered 834 audit findings, including 141 high-priority findings. It identified that 60% of findings related to the operation of existing controls rather than their design, indicating that processes were often established but were not being applied consistently.

Governance and Information and Data Quality were the most common themes. Governance findings included outdated Terms of Reference and weaknesses in meeting, minute and action-tracking arrangements. Data-quality findings principally related to missing, incomplete or inconsistently recorded information. The Committee noted that the analysis would help inform consideration of the Health Board's operating model, assurance arrangements and future audit coverage.

AUDIT TRACKER REPORT
The Committee was advised that significant proportion of Internal Audit and Audit Wales actions remained overdue.

While actions continued to be completed, delivery was not always taking place within agreed timescales. This could reflect competing organisational priorities, insufficient capacity or deadlines that had not been realistic when initially agreed.

It was agreed that the Corporate Governance Team will strengthen its monthly scrutiny of overdue actions. Relevant information will also be incorporated into Clinical Board Reviews, with a parallel mechanism developed for actions assigned to Executive and corporate areas. The effectiveness of the revised performance-management arrangements will be reported to the Committee in February 2027.

The Committee stressed the importance of maintaining focus on high-priority actions.

AUDIT WALES UPDATE:
Planning and interim testing for the 2026/27 accounts audit will take place during autumn and winter 2026. Audit work on the 2025/26 Charitable Funds Accounts will also be undertaken, with certification intended by the end of January 2027.

The Clinical Coding, Local Cancer Services and Digital Transformation reviews had been completed. The draft Estates Management report had been issued to the Health Board for clearance and was expected to be presented to the Committee in November 2026. The 2026 Structured Assessment was also underway, with an increased emphasis on organisational effectiveness and impact.

The principal issues arising from the completed reviews were:

- **Clinical Coding**: Progress had been made through clearer management arrangements, improved workforce stability, investment in staff development and continued visibility at Board level. Further improvement was required in relation to coding performance, vacancies, medical records, clinical engagement, improvement planning and Board oversight. Six recommendations were accepted by management. Coding completion was reported as 83% for April 2026 and 84% for May 2026.
- **Local Cancer Services:** Performance against the 62-day target was 63.2% in March 2026 against a target of 75%. The review identified the absence of a single costed plan for delivering the cancer strategy and meeting future demand, alongside weaknesses in forecasting, capacity modelling and the use of patient-experience and outcomes information. Governance arrangements also required strengthening through the appointment of a Clinical Cancer Lead and re-establishment of the Cancer Board. Six recommendations were accepted. The Committee supported the development of both short and longer-term costed improvement plans.
- **Digital Transformation**: The Health Board was assessed as having a reasonably clear strategic approach and oversight arrangements. However, Clinical Board responsibilities were not clearly defined; controls relating to digital infrastructure, cyber security and artificial intelligence were not fully effective; and the organisation did not have a comprehensive understanding of workforce digital skills. Eight recommendations were agreed. The Committee emphasised the importance of digital transformation in supporting improvements in data quality, clinical coding, patient information, organisational performance and patient outcomes.

RISK MANAGEMENT
The Committee received a consolidated update on the actions and recommendations concerning risk management arising from Internal Audit, the Audit Wales Structured Assessment, the Health Board's escalation arrangements and correspondence from Welsh Government.

A revised Corporate Risk Register was presented. The previous approach of reporting all organisational risks scoring 20 or above had become unmanageable following the consolidation of approximately 70 to 80 risk registers into AMaT. The combined organisational register contained more than 1,400 risks, including over 100 risks scored at 20 or above.

The consolidated information had therefore been analysed by common causes and effects, supporting the development of 13 corporate risks affecting the organisation. Although further work was required to strengthen the description of some controls, the Committee considered that the revised register represented a more credible and focused account of the Health Board's principal corporate risks.

The revised Corporate Risk Register was endorsed by the Committee for submission to the Board later in September 2026 for approval.

PROCUREMENT COMPLIANCE:
The Committee noted continued improvement in procurement compliance. There had been 42 instances of non-compliance during the year to date, including 27 in the latest reporting period. This was 11 fewer than during the equivalent period in the previous financial year.

One Single Tender Action had been recorded during the latest reporting period, compared with 22 across the previous financial year. Earlier engagement with Clinical Boards was helping to ensure that requirements above £5,000 were referred to Procurement before commitments were made. Future reports will include further year-on-year analysis of the financial value of non-compliant activity.

CAR PARKING PROCUREMENT - LESSONS LEARNT:
The Committee received a lessons-learnt report following the procurement process for the car parking contract. Although legal and counsel advice had been obtained, an application to lift the suspension of the procurement process had been unsuccessful.
The Health Board had reviewed its approach and identified lessons to strengthen future procurement exercises. These included greater focus on internal processes, senior-level consideration of the prospects of future applications to lift procurement suspensions and improvements to tender documentation.

POST PAYMENT VERIFICATION:
The Committee received the Post Payment Verification End of Year Report for 2025/26. All planned General Medical Services routine visits and outstanding General Ophthalmic Services visits had been completed. The new three-year cycle for 2026/27 had commenced and the programme remained on schedule.

The Committee noted that Post Payment Verification supported not only financial recovery but also organisational learning, prevention and service improvement. Power BI dashboards were being developed to improve the presentation and oversight of Post Payment Verification information provided to Audit Committees

ITEMS REFERRED TO THE BOARD OR OTHER COMMITTEES:
Findings and outstanding actions arising from the Five Steps of Safer Surgery audit would be monitored through the Quality Committee.

The Reducing Health Inequalities audit, concerning ethnicity data, would receive further consideration through the Quality Committee.

The revised Corporate Risk Register would be submitted to the Board for approval.

The Committee also noted updates relating to Counter Fraud

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

none

Recommendations:

a) Note the contents of the Audit & Assurance Committee Chairs 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 Ways 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		x	n/a

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

Risk: n.a
Safety: n.a
Financial: n.a
Workforce: n.a
Legal: n.a
Reputational: n.a
Socio Economic: n.a
Equality & Health: n.a
Decarbonisation: n.a
Welsh Language: n.a

Report Title:	People & Culture Committee – Chair's Report					Agenda Item no.	6.5.5
Meeting:	Board		Public	x		Meeting Date:	24.09.2026
			Private				
Status *(please tick one only):*	Assurance	x	Approval	x	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 People & Culture Committee meeting held on the 08th September 2026.

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

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

Improving Attendance and Wellbeing
The Committee noted that the 12-month cumulative sickness absence rate was 6.3% at the end of July 2026, which remained above the Health Board target of 5.5%. Stress, anxiety and depression continued to account for approximately one-third of sickness absence, while long-term absence represented approximately two-thirds of the overall position.

The Committee welcomed evidence of improvement arising from targeted interventions but requested clearer measures demonstrating their effectiveness and sustainability. Future reports should provide a clear link between the issue identified, the intervention, the expected impact, the timescale for improvement and the evidence that the intervention is working.

Staff Story
The Committee received a positive staff story demonstrating how participation in leadership and management development had improved confidence in managing difficult conversations, supporting colleagues and building effective teams.

The key message was that leadership is demonstrated through behaviours and actions and is not dependent upon an individual's position within the organisational hierarchy. Wider use of the staff story within leadership programmes and internal communications will be considered, subject to the employee's consent.

Workforce Equality Standards
The Committee considered the Health Board's position against the Workforce Equality Standards. The report identified severe inequity in leadership and progression and in workforce wellbeing and safety. Moderate inequity was identified in relation to workplace behaviours and working conditions.

The committee did not receive assurance on the HB's proposed response as further detail was required. Further detail was required regarding the actions to be taken, accountable owners, delivery timescales, anticipated impact and measures of success.

The Committee was advised that a prioritised organisational response would be developed, with progress reported through future Committee meetings.

Key Workforce Performance Indicators
The Committee noted improvements in fire safety training compliance and staff turnover. However, the majority of workforce measures remained off target, including bank and agency performance.
Future reports will provide a clearer breakdown by staff group and explain the relationship between substantive workforce levels, bank and agency expenditure, workforce controls and the overall pay bill.

The cultural dashboard and heat map were expected to be operational by November 2026. The Committee requested that the next update also explain the support and interventions that will be available when emerging cultural concerns are identified.

Medical job planning compliance remained below the Welsh Government target of 90%. The Committee received assurance regarding the actions being taken to improve compliance and the development of a revised All Wales reporting approach.

People and Culture Strategic Plan Refresh
The Committee supported the principle of bringing the People and Culture Plan and Health and Safety Culture Plan together into a single strategic plan for 2026 to 2030.

However, the Committee did not receive full assurance regarding the refresh and engagement process. Concerns included the level and breadth of staff engagement, the need to demonstrate how previous Staff Survey findings had informed the plan, whether the proposed November timetable allowed sufficient opportunity for scrutiny, how engagement is framed, what the refresh is intended to achieve and expected outcomes and success measures.

It was noted that equality should be made explicit as a golden thread throughout the plan and the Committee was advised that Executive colleagues would consider whether the plan should return to the Committee in November 2026 or whether additional development time was required.

Welsh Resident Doctor Contract and Medical E-Rostering
The Committee received an update on implementation of the new Welsh Resident Doctor Contract. Resident doctors commencing in August 2026 were working compliant rotas, with further work continuing on a small number of rotas commencing later in the year.

Local modelling indicated an implementation cost of approximately 5.85%, compared with the 4% national funding envelope. The estimated cost pressure for 2026/27 was £1.8 million. After anticipated Welsh Government funding, the estimated local pressure was £1.2 million.

The estimated recurrent pressure, including additional posts required to maintain contractual compliance, was approximately £5.8 million per annum. The financial implications will be reported through the Finance and Performance Committee and onward to the Board.

Welsh Language Skills
The Committee noted that the recording of staff Welsh language skills had improved to 81.02%, against the organisational target of 85%.

Welsh language skills information is now captured through recruitment and onboarding processes. The Health Board was awaiting a response from the Welsh Language Commissioner regarding the previously reported non-compliance. Any resulting enforcement action will be reported to the Board.

Clinical Board Spotlight – Surgery
The Committee received a presentation from the Surgery Clinical Board highlighting its workforce position and improvement activity.

The Committee welcomed progress through the Theatres Together programme, with more than half of its 66 recommendations completed. Staff feedback indicated improvement in pride, team support and leadership visibility, although concerns remained regarding workload, burnout, infrastructure, staffing and development opportunities.

The Committee also received updates on improvement work within the Hospital Sterilisation and Disinfection Unit and the Surgical Short Stay Unit. The latter was acting as a pilot for the cultural early warning system following staff feedback regarding morale, trust and psychological safety.

Reports Approved
The Committee:
• Approved the Equality and Inclusion reports for publication;
• Noted that a separate workforce representation report would be published alongside the Equality and Inclusion reports;

• Approved the Social Partnership Duty Annual Report for publication and submission to the Social Partnership Council for Wales; and
• Supported the proposed Social Partnership Duty areas of action for the coming year.
The Committee also noted that the average gender pay gap had reduced from 16.73% to 16.37%. The gap related to workforce representation, with a higher proportion of men occupying higher-paid roles, rather than unequal pay for the same work.

The Digital Communications & Analytics were noted.

Private Items received by the Committee included:

- People & Culture Updates
- Employee Relations Cases

In relation to the Employee relations activity, the Committee discussed a small number of recent cases which highlighted the need for continued assurance regarding the consistency and robustness of disciplinary processes and outcomes across the Health Board. Members noted that a review was underway and welcomed the development of additional measures to strengthen oversight, training and decision-making arrangements. The Committee requested further updates on improvement actions and lessons learned and agreed that this emerging area should be brought to the Board's attention via this Committee Chairs Report.

Recommendations:

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

1 Putting People First	x	2. Providing Outstanding Quality	x
3. Delivering in the Right Places	x	4. 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:	Charitable Funds Committee – Chair's Report			Agenda Item no.		6.5.6
Meeting:	Board		Public	X	Meeting Date:	24.09.26
			Private			
Status:	Assurance	X	Approval		Information	
Lead Executive:	Director of Corporate Governance					
Report Author:	Senior 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 Charitable Funds Committee meeting held on 15.09.2026

The papers for this meeting, outlining all of the detail on the below items, can be found on the CAVUHB website **linked 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 meeting, and a brief synopsis of the principal matters discussed is set out in this report.

Over £25k endowment expenditure for approval: There were no items for approval.

Health Charity Policies and Protocols: The Committee received a suite of policies and protocols which had been developed to strengthen the governance and compliance arrangements supporting the Health Charity. The suite comprised:

- UHB 601 – Protocol for Using Charitable Funds to Support External Third Sector Organisations and Individuals;
- UHB 602 – Conflict of Interest Policy (Health Charity);
- UHB 603 – Privacy Policy (Health Charity);
- UHB 604 – Complaints Policy and Procedure (Health Charity); and
- UHB 605 – Ethical Fundraising Policy.

The Committee was advised that the policies had undergone a 28-day consultation period and had been amended in response to feedback. Members sought assurance that the requirements within the External Funding Protocol would not create unintended barriers for smaller third sector organisations. Assurance was provided that arrangements were in place to assist third sector partners with the relevant financial and administrative requirements, while ensuring appropriate probity, scrutiny and oversight.

The Committee noted that implementation of the policies would extend beyond the Health Charity, particularly where charitable funds or commercial sponsorship arrangements were involved across the wider Health Board.

The policies and protocol were approved by the Committee.

Memorandum of Understanding with World Child Cancer UK: The Committee received a proposed Memorandum of Understanding between the Health Charity and World Child Cancer UK. The Memorandum of Understanding would formalise and strengthen the governance arrangements supporting a long-standing programme of work in Sierra Leone, which included the provision of chemotherapy treatment for children and the training of healthcare professionals.

The Committee noted that the Memorandum of Understanding was also progressing through World Child Cancer UK's governance arrangements and could therefore be subject to minor amendments.

The signing of the Memorandum of Understanding with World Child Cancer UK was approved by the Committee.

Health Charity Financial Position and Investment Update: The Committee received the financial position and investment update and was advised that the value of the charitable funds had increased by £359k in the year

to date to the end of July 2026. This principally comprised investment portfolio growth of approximately £300k and income exceeding expenditure by £59k.

Total charitable funds stood at £9.8m, with year-to-date income of £445k. Donation income and Staff Lottery income had performed positively, although legacy income remained inherently unpredictable. The Committee was also advised that £24k had been reallocated to the General Fund under the revised income distribution arrangements.

The General Fund was forecast to have a year-end deficit of £664k, potentially increasing to £730k by 2028/29. The Committee noted that investment had been made in expanding the Charity Team to support the generation of unrestricted income and improve the fund's longer-term sustainability.

Members emphasised that reliance upon unrealised investment growth would not provide a long-term solution to the General Fund deficit. The Committee highlighted the need for a clear plan setting out future expenditure, income-generation activity and priorities for the Health Charity, allowing progress to be monitored against agreed objectives. Work was underway to develop a more integrated reporting approach combining financial performance, fundraising activity, future plans and mitigating actions.

The Committee also noted that Rathbones had been reappointed as the Health Charity's investment manager following a procurement process. Investment markets remained volatile, although current cash-flow forecasts indicated that there would be no requirement to sell investments during the financial year.

Health Charity Risk Register: The Committee received the newly developed Health Charity Risk Register, which formed part of the wider programme of work to establish an effective governance and compliance framework for the Charity.

The Committee was advised that 22 risks had been identified, of which 14 were assessed as being outside the organisation's risk tolerance. It was acknowledged that this position was not acceptable in the longer term, but the identification and transparent reporting of the risks provided an important baseline against which improvements could be monitored.

A number of risks were expected to reduce following implementation of the newly approved policies and other mitigating actions. The Risk Register was being transferred to the Health Board's corporate risk management system, ensuring alignment with the wider organisational risk framework and improving transparency and oversight.

Members requested that future reports include the relevant risk scores and prioritisation information. The Committee noted the intention to receive future updates by exception, approximately every six months, enabling it to monitor progress and provide appropriate challenge.

Case Study of Impact: The Committee received a case study demonstrating the impact of charitable funding within maternity services. The case study represented the start of a programme of impact-focused reporting intended to demonstrate the benefits and outcomes delivered through charitable funds.

The Committee strongly supported the inclusion of regular impact reporting within future agendas. Members emphasised that demonstrating how charitable funds were raised and used would be important in encouraging future donations, strengthening public engagement and maintaining a clear focus on benefits for patients, staff and local communities.

Health Charity Fundraising Report: The Committee received the quarterly fundraising update and noted the intention for future reports to place greater emphasis on forward planning, strategic fundraising priorities and the development of larger fundraising campaigns.

Early work was underway on a potential robotics fundraising campaign to support the acquisition of a Da Vinci XI robotic surgical system. This was intended to act as a pilot for how the Health Charity could support major initiatives which could not be funded through statutory resources.

The Committee was also advised of potential fundraising and engagement opportunities associated with the National Eisteddfod coming to Cardiff in two years' time, coinciding with the 80th anniversary of the NHS.

Members further noted the development of partnership opportunities linked to the South East Wales Health Park, involving Cardiff and Vale University Health Board, Cwm Taf Morgannwg University Health Board and Aneurin Bevan University Health Board. Discussions were considering how charitable funds could support enhanced outdoor spaces promoting rehabilitation, wellbeing and staff welfare.

Noah's Ark Children's Hospital Charity Rebranding: The Committee received a verbal update on the rebranding of Noah's Ark Children's Hospital Charity, following its earlier consideration in June 2026. It was reported that agreement had been reached to proceed and that replacement signage was scheduled to be installed during the final week of September 2026, ahead of the Cardiff Half Marathon.

The Committee sought assurance that Welsh-language requirements would be considered as part of the signage changes. It was confirmed that Welsh-language considerations had been raised through the process, although final proofing and approval of the signage rested with the Children's Hospital. Support from the Health Board's People and Culture Team was offered if required.

NHS Charities Together Presence at the NHS Confederation Wales Conference: The Committee was advised of a possible NHS Charities Together presence at the NHS Confederation Wales Conference in November 2026. Should this proceed, the Cardiff and Vale Health Charity would support the initiative by providing appropriate stories and promotional materials to showcase the impact of charitable funding and raise awareness of the Charity's work.

A private session of the Charitable Funds Committee was held where the Committee received and approved the Health Charity Strategic Plan, which set out the proposed strategic direction and future development of the Charity. Further detail is not included within this report due to the confidential nature of the matters considered in private session

Recommendation:

The Board are requested to:

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

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

1. Putting People First **Click the objective above to view more detail.**	x	Providing Outstanding Quality 2. **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 4. **Click the objective above to view more detail.**	x

Five Ways of Working (Sustainable Development Principles) considered

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Quality Impact Assessment Completed?

Yes		No		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	
Committee/Group/Exec	Date:

Report Title:	**Strategic Planning, Commissioning and Partnership Update**				Agenda Item no.	6.6
Meeting:	CAV Board		Public	X	Meeting Date:	24.09.2026
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive Title:	Executive Director of Strategy, Planning and Partnerships Executive Director Finance					
Report Author (Title):	Executive Director of Strategy Planning and Partnerships Executive Director of Finance					

Main Report
Background and current situation:

This report provides the Board with an update on key areas of the strategic planning and partnerships and commissioning corporate work programmes. It includes relevant updates in relation to the following areas:

1. 27/28 Annual Plan
2. Commissioning
3. Strategic Portfolio progress
4. Partnership updates:
    a. Regional Partnership Board
    b. SEW Regional Joint Committee
    c. Regional Specialised Services Provider Planning Partnership
5. Engagement for service change and Llais update
6. Planning Maturity self-assessment

The central focus of this report is the continued alignment of the strategy and strategic plans including the Clinical Services Plan, annual planning priorities and commissioning intentions into a coherent delivery framework for 2027/28. This is intended to ensure that strategic priorities are translated into clear planning requirements, measurable outcomes, and realistic expectations for Clinical Boards and corporate teams.

The key issues for Board attention are the deliverability of planning ambitions within financial and estates constraints, significant external dependencies across regional programmes, and the material risk associated with the end of RIF funding in March 2027.

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

1. 27/28 Annual Plan

The 27/28 annual planning process has been refreshed taking learning from the 26/27 planning cycle and resulting feedback from the Welsh Government.

An Annual Plan Development Group has been established to provide governance and oversight, chaired by the Deputy Director of Strategy, Planning and Partnerships with the Executive Director acting as Senior Responsible Officer.

Phase 1 of the process has now been completed. This established the organisational baseline assessment across quality, workforce, finance and performance and has informed five

organisational priorities, key planning conditions and assumptions, which were considered at the Board Development session in August. Board members identified the need for an additional priority, relating to the physical environment in which services are delivered reflecting ongoing concerns raised by staff about the condition of facilities. While this is an important issue for workforce experience and service delivery, there is also a need to manage expectations carefully given the current capital and affordability constraints.

These priorities form a critical part of the planning process alongside clear "planning requirements" which act as the early principles, boundaries and expectations (guardrails). Collectively these priorities and requirements inform the organisational Commissioning Intentions (CI) which are the focus of phase 2 of the planning process which is due to complete by the 1st October. Phases 1 and 2 provide the cornerstone of the process, ensuring the organisation is positioning itself to develop a realistic, deliverable, financially sustainable annual plan that is strategically aligned to the agreed 27-28 priorities.

2. Commissioning

The Cardiff and Vale University Health Board 2027/28 commissioning intentions have been drafted to reflect:

- Shaping Our Future Wellbeing Strategy
- Clinical Services Plan
- Baseline Assessment for 2025/26
- Targeted Intervention requirements
- 2027/28 Planning Assumptions, Parameters and Priorities
- Public Health priorities
- Financial recovery and turnaround requirements
- Regional and National planning requirements
- Accountability Framework domains

This will ensure that we have one plan to address all of these, instead of multiple plans.

Formative engagement is taking place throughout mid-September, and feedback will be used to shape and refine the intentions. A finalised set of organisational commissioning intentions, detailing the changes expected, and outcomes required by 31 March 2028 will be produced at the end of September, and will inform provider planning.

The commissioning intentions are either directly related to the priorities detailed in the Clinical Services Plan, or act as an enabler, supporting delivery of those priorities. Every commissioning intention will have a quantified (where possible), measurable 2027/28 target that will be monitored as part of organisational performance arrangements from 1 April 2028. These targets will:

- Be informed by existing Welsh Government standards or deescalation criteria where they exist, or locally agreed targets where these differ from national standards.
- Use national benchmark performance (top quartile NHS Wales where no formal target exists).
- Use improvement trajectories from the Baseline Assessment where performance is materially off benchmark.

The NHS Wales Joint Commissioning Committee (NWJCC) is also undertaking engagement on draft commissioning intentions for the 2027–30 NWJCC Integrated Medium Term Plan (IMTP). A commissioning intentions workshop took place on 3rd September with Health Board representatives.

3. Strategic Portfolio Progress

The Quarter 2 updates are due to be reported to Finance and Performance Committee in October and a more detailed overview will be provided to Novembers Board meeting. Key highlights this month include:

- Clinical Services Plan (CSP), priorities for the next 3 years have informed the Annual Plan priorities and Commissioning Intentions to ensure focus on delivery.
- The Community by Design Programme, which is focused on delivery of the future model of care supporting the enabling health and wellbeing care domain, has been mobilised. A communication and engagement plan has been developed and has commenced with focused internal and external engagement with partners and across the organisation. The programme has expanded its scope to include the Urgent and Emergency Care programme to ensure alignment and reduce duplication.
- Partnership working continues to progress across a number of areas and is a critical enabler for the delivery of our population health objectives and the future single integrated model of care. See item 4 for specific updates.
- The Quality Excellence Programme remains on track, supported by the introduction of a new Scan Safety project, while progress continues in clinical audit, PROMs expansion and value-based healthcare initiatives.
- The People and Culture Plan is completing the engagement phase and is due for submission to the Board in draft in January.
- Both Digital and Estates continue to progress with The Digital Foundations five-year programme now aligned to the CSP and the development of a long-term vision for UHW and UHL has commenced.

4. Partnerships

Partnership working remains central to delivery of the Health Board's strategic objectives, particularly in areas such as integrated community care, prevention, admission avoidance, discharge, digital and data solutions, and community infrastructure.

4a) Cardiff & Vale Regional Partnership Board

The focus of the RPB is on improving health and wellbeing outcomes for people through better, seamless care across the NHS, Local Authorities and third sector. The Partnership's priorities are set out in the Joint Area Plan 2023:28

Integrated Community Care System for Cardiff and Vale

The Community by Design programme provides the Health Board's contribution towards the ambition of an Integrated Community Care System for C&V. The national programme describes three 'shifts' towards prevention and population health management, chronic conditions and urgent and same day care. All three will require a strong partnership approach to succeed given that many of the solutions to those shifts rest with the LAs and third sector, particularly around the delivery of improved population health and prevention. It is critical that as a Health Board we strive to address the fragmentation currently experienced by patients and citizens as the new integrated models of care emerge.

Strong partnership arrangements are essential to prevent avoidable emergency admissions to hospital and to deliver on reducing length of stay, particularly supporting people with significant onward care and support needs and in their First 1000 Days

Digital and data solutions.
The RPB's Digital Care Region programme is driving the development of inter-organisational digital and data solutions as a major enabler of a shared understanding of our population and the demand that arises from it. The ability for staff from different services and organisations to access records across multiple systems is a critical enabler of the delivery of the ambitions of the ICCS. The Health Board's work to develop population health management capability will be delivered in partnership with our two LA partners.

Community infrastructure.
Partners come together under the Partnership Asset Management Board to work together on strategic opportunities associated with capital developments led by different partners. There is a need to develop the Health Board's community infrastructure strategy and delivery plan as a critical enabler of Community by Design. The are significant opportunities to be had from partnering with the LAs to deliver integrated community hubs, housing with care, sites for service co-location and delivery.

Key risks to note:

- Regional Integration Fund (RIF) risk:

Confirmation by Welsh Government of funding beyond 31.03.27 remains outstanding. Representation has been made to the Cabinet Minister by all seven RPB Chairs across Wales, however the response received this week did not provide any confirmation or indication of funding beyond this financial year.

The Health Board receives £6.5m of a total RIF pot of £20.3m. This directly funds services across a range of Clinical Boards. In addition, a significant amount of the funding made to both Local Authorities supports admission avoidance, flow and discharge arrangements for example Discharge to Recover and Assess step down placements and Discharge to Assess rapid access care packages enabling discharge.

The table below provides an overview of the breadth of services supported by the RIF. The interconnection between funding to each of the partner organisations should be recognised, given the purpose of the RIF to develop integrated models of care.

Programme					
RIF Programme	Cardiff LA	Vale LA	Third Sector	UHB	Total
Digital	0	16,000	0	393,582	409,582
ICCS (At Home)	5,173,785	1,406,005	415,610	1,964,973	8,960,373
emPower	2,071,549	672,926	275,100	1,105,779	4,125,354
Complex Health and Learning Disability	174,939	158,310	0	487,079	820,328
Learning Disabilities	1,022,540	530,779	140,000	176,851	1,870,170
Unpaid Carers	222,000	0	216,000	41,042	479,042
Autism	0	0	0	397,728	397,728
Dementia	231,573	268,000	135,000	1,193,018	1,827,591
Capital Revenue	289,435	67,315	25,000	68,250	450,000
Infrastructure	20,000	20,000	45,000	705,726	790,726
Total	9,205,821	3,139,335	1,251,710	6,534,028	20,130,894

A risk assessment undertaken by the RPB in March this year, assessed which of the RIF-funded services would create the greatest risk to the partnership if funding did not continue.
The table below demonstrates that most of the funding is associated with services that if closed would create a high degree of risk to the system.

	Cardiff LA				Vale LA		Third Sector			UHB			
	Allocation	Number of services	Indicative wte	Allocation	Number of services	Indicative wte	Allocation	Number of Services	Indicative wte	Allocation	Number of Services	Indicative wte	Allocation
Low System Impact	£0	-	0	£0	-	0	£0	-	tbc	£238,276	2	4	£238,276
Medium System Impact	£1,088,965	8	11	£986,187	7	15	£305,100	4	tbc	£1,757,561	8	51	£4,137,813
High System Impact	£8,116,856	15	133	£2,153,148	13	60	£946,610	9	tbc	£4,538,191	14	106	£15,754,805
	£9,205,821	23	144	£3,139,335	20	75	£1,251,710	13	tbc	£6,534,028	24	161	£20,130,894

Examples include services to support children and young people with highly complex emotional wellbeing and mental health needs, learning disability and autism services, hospital to home, and a range of services central to the delivery of Community by Design, and delivery of digital solutions to support integrated delivery e.g. summary care viewer.

It is estimated that c.380 staff are funded through the RIF (plus staff hosted by the third sector). In the Health Board, there are c.161 staff funded by the RIF.

At the March RPB, partners agreed to hold the line collectively and to avoid precipitous decisions to give notice to staff or services. There was a strong recognition that service benefits span across partners so decisions made unilaterally by one partner would impact the others.

Depending on the nature of service and staffing contracts, a prudent planning assumption would be to commence consultation associated with a service closure a minimum of 6 months in advance. This would be from 01.10.26 for any services likely to close after 31.03.27.

There will also be significant redundancy costs associated with service closures which have not yet been quantified or funded across partner organisations.

Partners continue to make frequent and strong representation to Welsh Government to confirm RIF funding beyond 31.03.27.

- Community by Design's contribution to the overarching partnership Integrated Community Care System

Community by Design is the Health Board's key contribution to the delivery of the ICCS and it is critical that the programme strengthens its recognition the role of LAs and third sector in delivering its ambitions, particularly around prevention and early intervention. It is the main programme within the Health Board to deliver the ambitions set out in the Clinical Services Plan.

There is a risk that Community by Design focuses too much on the significant changes needed with the Health Board and misses the opportunities of developing fully integrated community services which address the fragmentation experienced by many citizens. To mitigate this, the RPB is supporting the project management of the development of Integrated Neighbourhood Teams, ensuring a whole partnership approach.

4b) South East Wales Regional Joint Committee

Regional working continues to provide opportunities to improve patient access to services, reduce unwarranted variation in care, strengthen workforce sustainability and make better use of available capacity across South East Wales. By working together, Health Boards are seeking to ensure that patients receive timely, high-quality and consistent care, regardless of where they live. Continued progress will rely on strong collaboration across organisations and the delivery of agreed regional priorities that improve outcomes and experiences for patients.

Cross-Cutting Workplan Update

- **Elective Recovery Response**: A Regional Planned Care Board is being established to provide oversight of recovery programmes, supporting improvements in waiting times and ensuring patients can access planned care services more quickly across the region.
- **Organisational Development Support**: CoCreate has been appointed to support the Regional Joint Committee in strengthening regional collaboration and leadership arrangements, helping partners work more effectively together to improve patient services and outcomes.
- **Clinical Service Planning**: A regional group has been established to develop a consistent approach to assessing and planning clinical services, ensuring future service models are designed around population need and patient outcomes.
- **Integrated Medium-Term Planning (IMTP)**: Work is underway to develop a shared demand and capacity planning approach, supporting more effective use of resources and helping organisations respond to future patient demand in a coordinated way.

Regional Orthopaedics Programme
Progress in delivering the Regional Orthopaedics Programme and associated Local Health Plan capital developments will support more sustainable orthopaedic services and improved patient access to treatment.

Key highlights include:

- Submission of the Programme Plan and Full Business Case to Welsh Government for approval, representing an important step towards delivering long-term improvements in orthopaedic care and patient outcomes across the region.
- Development of governance arrangements for the next phase of delivery, ensuring implementation remains focused on achieving benefits for patients.
- Agreement of a regional performance framework, enabling consistent measurement and monitoring of improvements in access, quality, productivity and patient outcomes.

Regional Diagnostics Programme (Radiology, Endoscopy and Cellular Pathology)

Improving diagnostic services remains a key priority, recognising the importance of timely diagnosis in reducing delays to treatment and supporting better patient outcomes.

Key highlights include:

- A review of the radiology demand and capacity methodology is underway to support future planning and improve access to diagnostic imaging services.
- Agreement has been reached with HEIW regarding the requirements for the Endoscopy Academy at the CDH site, subject to funding and formal approvals. The Academy will support workforce development and help increase endoscopy capacity across the region.
- Development of the Strategic Outline Case for Cellular Pathology continues in line with the agreed programme timetable, supporting the creation of more resilient and sustainable pathology services.

Regional Ophthalmology Programme

The ophthalmology programme is focused on improving patient access to care, reducing waits and ensuring services are sustainable for the future.

Key highlights include:

- A pathway-based workforce planning approach is being piloted, initially focusing on cataract services, to ensure the workforce is aligned to patient need and future demand.
- Workshops with Digital Health and Care Wales are exploring regional solutions for waiting list management, supporting more equitable access to care and improved patient flow.
- Demand and capacity analysis for glaucoma and medical retina services is underway to inform future service planning and ensure services can meet growing demand.
- Recovery plans for cataract services have been agreed, aimed at reducing waiting times, increasing treatment capacity and improving patient access to care. Discussions regarding future provider arrangements for 2026/27 are continuing to support the delivery of sustainable services.

Regional Cancer Programme:

- Supporting the commissioning and mobilisation of the New Velindre Cancer Centre, helping to ensure patients across South East Wales have access to modern, high-quality cancer treatment facilities and an improved care experience.
- Establishment of a Regional Patient Treatment List (PTL), with plans to transition all referrals to a fully electronic system by January 2027. This will improve the visibility and management of patient pathways, support more timely access to treatment, and help ensure patients are seen in the right place at the right time across the region.

4c) Specialised Services (including the Regional Specialised Services Provider Planning Partnership (RSSPPP) with SBUHB)

Specialised services present both strategic opportunities and material delivery risks, particularly where future service models depend on commissioner decisions, workforce capacity, infrastructure and collaboration.

2026 Baseline Assessment and Annual Plan Priorities

The baseline assessment of specialised and tertiary services is nearing completion. The next phase includes a review and moderation of risk assessments to ensure consistency across the organisation, alongside incorporation of service-specific contracting and financial information. This will provide a comprehensive understanding of service risks, dependencies and opportunities, supporting collaborative action with partners to strengthen service provision and improve patient outcomes.

Work has commenced to establish a baseline of contracting arrangements for specialised services that are not commissioned through the NHS Wales Joint Commissioning Committee (NWJCC), working in partnership with neighboring health boards to develop a clearer understanding of current provision and future opportunities.

The Health Board continues to engage closely with NWJCC and NHS Performance and Improvement in the development of a strategic plan for specialised services, which will form part of the wider National Clinical Services Plan.

Existing Services

Following the prioritisation of funding within the NWJCC 2026/27 Annual Plan, the Health Board has been invited to submit a business case for investment in the Hereditary Anaemia Service. The case is currently progressing through internal governance processes and is scheduled for submission to the NWJCC in October 2026.

The Regional Specialised Services Provider Planning Partnership continues to oversee strategic service planning for cardiac and gynae-oncology services. This includes ongoing collaboration with Swansea Bay University Health Board and the NWJCC, particularly in relation to the Cardiac Surgery Review and its implications for future service configuration.

New Services

The Health Board has expressed an interest in becoming a provider of Selective Internal Radiation Therapy (SIRT) and a Functional Neurology Service, the latter in collaboration with the University College London Hospitals (UCLH) Neurosurgery Team. Business cases have been developed and submitted through internal governance processes for Health Board approval, pending conclusion of the NWJCC's provider selection process.

Advanced Therapies

An inaugural meeting of the Advanced Therapies Provider Planning Group (ATPPG) is planned for Quarter 3. The Group will provide a collaborative planning forum for the main providers including Cardiff and Vale University Health Board, Swansea Bay University Health Board and Velindre University NHS Trust, with scope to include additional health boards over time.

Reporting through the RSSPPP, the ATPPG will support strategic planning and preparedness for the introduction of advanced therapies. The Group will be informed by the National Horizon Scanning Operational and Delivery Group, a sub-group of the All Wales Medicines Strategy Group (AWMSG), and will work closely with commissioners to ensure alignment between emerging treatment opportunities and service capability.

Since the last report, we have been asked to provide an early assessment of our ability to deliver:

- CAR-T therapy for patients with multiple myeloma.

- Onasemnogene abeparvovec gene therapy for paediatric patients with spinal muscular atrophy.

Initial discussions have identified that the paediatric service is currently not in a position to deliver Onasemnogene abeparvovec. In relation to CAR-T therapy for multiple myeloma, further work is required across the haemato-oncology pathway to create capacity and develop the infrastructure necessary to support delivery.

The ATPPG will play a key role in ensuring organisational readiness for the introduction of new and advanced therapies, supporting coordinated provider planning and enabling a consistent, sustainable approach to service development across the region.

5. Engagement for Service Change and Llais update

Shaping Our Future Wellbeing Collaborative

The first meeting of the collaborative was held on the 14th September. Expressions of interest are now open for the expressions of interest for Chair who will be an associate member of the board, and Vice Chair are open for members to apply closing 28th September. Voting will then close on the 14th October.

Once agreed, the Cabinet Minister will approve the chair and report into the next board meeting. This is expected to be finalised by the end of October and the next collaborative meeting to be held in December.

SEW Regional Engagement

Phase one of the SEW regional communications and engagement plan will begin this month which includes a high-level survey and coordinated communications plan. This reports formally to the SEW Regional Joint Committee.

The first meeting of the regional patient involvement group met on the 3rd September and focused on the Llantrisant Health Park programme. Each health board attended with three patient representatives. The meeting was successful and the next date is currently being organised.

Continuous Engagement on strategic priorities

To ensure continual engagement with communities and colleagues on the Clinical Services Plan (CSP), an 18-month plan has been developed, this is informing a number of transformation programmes including Community by Design.

Llais Cardiff and Vale of Glamorgan - Regional Update: July to September 2026 - **Lauranne Cullen, Regional Director**

Championing People's Experiences and Driving Improvement

Throughout this reporting period, Llais Cardiff and Vale has continued to ensure that the voices and experiences of local people directly inform scrutiny, service improvement and decision-making across health and social care. Our work has focused on seeking assurance where concerns have been raised, promoting meaningful involvement in service changes, identifying emerging themes, and ensuring people receive clear communication and safe, high-quality care.

Ensuring Services work for the public

A significant area of focus has been ongoing scrutiny of services where concerns have been raised by patients, families and communities.

At **Lansdowne Ward, St David's Hospital**, we have continued to engage with Cardiff and Vale University Health Board following concerns about patient care and ward management. While the Health Board has outlined additional staffing measures and commissioned an independent senior nursing review, Llais has continued to seek assurance regarding immediate patient safety measures, governance oversight, audit findings, and the involvement of patients and families in improvement activity. This work remains active as we monitor progress and outcomes.

We have also continued to scrutinise the **Breast care pathway at Llandough Hospital**, where concerns about communication and delays following initial imaging have been raised. Applying our Service Change Decision Support Tool, we have formally challenged whether elements of the pathway should be considered under service change arrangements. Our focus remains on ensuring timely follow-up, clear communication, accountability and meaningful involvement of those affected.

Following reports of the proposed changes regarding **West 2 Ward at Llandough Hospital**, Llais has sought clarification from the Health Board regarding the rationale, consultation undertaken and potential impact on patients. We have emphasised the importance of transparency, patient safety and public involvement whenever significant service changes are being considered.

In the **Vale of Glamorgan**, we have continued work relating to dementia care and discharge arrangements, seeking greater assurance around how health and social care services work together to support individuals living with dementia and their families. We remain focused on ensuring information is accessible, responsibilities are clear and services are coordinated around people's needs.

Improving Access to Healthcare

Access to services continues to be a prominent theme across our work.

Following concerns from local residents regarding **prescription delivery charges**, we sought clarification regarding NHS arrangements for those who rely on medicines being delivered to their homes. This work has also informed our review of the Draft Pharmaceutical Needs Assessment, where Llais has advocated for a stronger focus on accessibility, equity and patient experience.

Within our **Penarth Locality Work**, community engagement activity has highlighted concerns relating to dental services, hospital care and primary care access. Through targeted representations and ongoing discussions with providers, we have focused on improving communication, care experiences, discharge processes, community support, accessibility and accountability. This work demonstrates how local intelligence gathered directly from communities is being translated into meaningful challenge and action.

Influencing National Issues

During the reporting period, Llais contributed to national scrutiny through work relating to the **Welsh Gender Service surgical pathway**. Concerns regarding the reported pause in surgical referrals and planned procedures prompted a national representation to the NHS Wales Joint Commissioning Committee. Our focus has been on ensuring patients receive timely information,

appropriate support and assurance that their safety and wellbeing remain central throughout the review process.

Listening to Communities and Strengthening Partnerships

Engagement remains at the heart of everything we do. Between July and September, teams attended a wide range of community events and engagement opportunities, including Brecon Pride, the Vale Show, Cardiff People First Ladies Group, the Gypsy and Traveller Open Day, and the Healthy Lives event at Cardiff City Stadium.

These events enabled us to hear directly from a diverse range of communities, raise awareness of Llais, and gather valuable insight into people's experiences of health and social care services. We also continued our local outreach through visits to healthcare settings, including Redlands Surgery and Penarth Healthcare Partnership.

Responding to Growing Public Need

Demand for support continues to increase, both in volume and complexity.

Our latest performance data highlights a notable rise in enquiries involving mental health concerns, acute emotional distress, safeguarding issues and complex cases requiring advocacy support. Increasingly, people are contacting Llais with concerns that span multiple organisations and services, often requiring significant support to navigate systems and access appropriate help.

In response, we have introduced measures to improve communication with people contacting us, while also strengthening staff support and developing additional approaches to manage increasing demand. Further work is underway to enhance staff training, particularly in relation to mental health awareness and complex case management.

Looking Ahead

Over the coming months, our priorities will be to:

- Secure timely and comprehensive responses to outstanding representations.
- Continue monitoring progress and assurance relating to Lansdowne Ward.
- Seek greater clarity and accountability regarding the breast care pathway and other emerging service changes.
- Use insights gathered through our Penarth locality work to shape future engagement and activity.
- Deliver/participate in planned mental health, youth and community engagement events.
- Develop our approach to prison healthcare engagement and representation.

Conclusion

This reporting period demonstrates the breadth and impact of Llais's work across Cardiff and the Vale. From influencing national policy discussions to resolving individual concerns, from scrutinising service changes to engaging directly with local communities, our role continues to ensure that people's experiences are heard, acted upon and used to drive improvement.

We will continue to work with partners to ensure that services remain accountable, that public voices influence decision-making, and that people receive safe, accessible and compassionate care across our region.

Case Study: Advocating for a Safe and Informed Clinical Pathway - August 2026

This case study highlights how effective advocacy ensured that a patient and his family were fully involved in decision-making, resulting in a revised clinical pathway that provided additional treatment options and improved pain management.

Background

Llais was contacted by a patient and his family following concerns about a proposed hospital discharge. The patient had been admitted for an elective angiogram and overnight stay due to significant vascular disease affecting their foot and toe. Although the procedure had provided some relief, there remained serious concerns regarding their ongoing vascular condition, severe pain, poor sleep, and the possibility of future amputation.

The family reported that discussions with the clinical team had focused primarily on the likelihood of toe removal and the associated risk that this could progress to the loss of part or all of the leg. They were increasingly concerned that discharge was being considered despite ongoing symptoms and uncertainty regarding the longer-term treatment plan.

At the time of referral, the patient stated that they felt generally well in themselves but had not received pain relief for approximately 12 hours and continued to experience significant discomfort. Follow-up appointments had been scheduled with vascular specialists and a joint clinic, but the patient and family felt they did not have a clear understanding of the overall treatment pathway or what alternatives might be available.

Advocacy Intervention

With the patient's consent, Llais contacted the ward to raise concerns and seek clarification regarding the proposed discharge.

The advocacy approach focused on:

- Clinical safety and discharge planning.
- The management of severe pain.
- The rationale for determining that the patient was fit for discharge.
- Whether all appropriate treatment options had been explored.
- The involvement of the patient and family in decision-making.
- The safeguards and support arrangements that would be in place following discharge.

Questions were raised regarding the patient's vascular status, consultant reviews, pain management arrangements, mobility, risk of deterioration, and the rationale behind discharge planning.

Llais also referenced relevant Welsh Government principles regarding patient and family involvement in discharge planning, together with Cardiff and Vale University Health Board's

discharge policy, which states that concerns raised by patients, carers, family members, or advocates should be considered and escalated where necessary.

A key aspect of the conversation was challenging whether discharge planning had fully considered the patient's current symptoms and whether there had been meaningful discussions about alternative treatment options beyond the pathway that had been presented to the family.

Issues Identified

Through discussions with the ward team, several concerns emerged:

- The patient and family did not feel adequately informed about the full range of available treatment options.
- Discussions had largely centred on amputation as the likely next step.
- The family had not been given a clear explanation of alternative clinical approaches that could potentially preserve tissue and improve outcomes.
- Ongoing pain management remained a significant concern.
- The family were unclear about the contingency plan should the patient's condition deteriorate while awaiting further review.
- There was uncertainty regarding who would have clinical responsibility during the period between discharge and specialist follow-up.

Most importantly, the patient and family felt they had not been fully involved in discussions about treatment planning and future care.

Outcome

Following advocacy intervention, the concerns raised by the patient and family were escalated and reviewed by the clinical team.

As a result:

- The proposed care pathway was reconsidered.
- Further discussions took place between clinicians, the patient, and family members.
- Additional treatment options were identified and explained that had not previously been discussed.
- The patient was provided with a clearer understanding of the potential benefits, risks, and implications of different treatment approaches.
- Pain management arrangements were reviewed, resulting in a more robust plan to support symptom control.
- The patient and family were given greater opportunity to participate in shared decision-making regarding future treatment.
- A revised clinical pathway was established, ensuring that decisions were based on a fuller assessment of available options rather than progressing directly toward the previously anticipated outcome.

The patient and family reported feeling significantly more informed, reassured, and involved in decisions about care.

Impact

This case demonstrates the vital role advocacy can play in ensuring that patients and families are active participants in healthcare decisions.

By asking detailed questions about clinical safety, discharge planning, treatment options, and pain management, Llais helped create an opportunity for further clinical review and discussion. The intervention did not challenge clinical expertise; rather, it ensured that decisions were transparent, patient-centred, and based on informed choice.

The outcome was a safer and more collaborative approach to care, with improved communication, enhanced pain management, and access to treatment options that had not previously been presented to the patient or his family.

This case highlights the importance of:

- Listening to and acting upon patient and family concerns.
- Ensuring meaningful involvement in discharge planning and treatment decisions.
- Providing clear information about all available treatment options.
- Reviewing discharge decisions when significant concerns are raised.
- Recognising the value of independent advocacy in supporting patient safety and informed decision-making.

Through timely intervention, the patient and family were empowered to participate fully in decisions about care, resulting in a more appropriate clinical pathway and an improved overall experience.

6. **Planning Maturity self-assessment**

The Welsh Government have confirmed that the Health Board is required to undertake a planning maturity self-assessment for 2026. A mandatory exercise required every autumn due to the organisations current level of escalation.

The assessment is intended to support honest organisational reflection and constructive challenge, helping Boards and Executive Teams evaluate the extent to which planning processes are integrated, evidence-based and aligned to delivery.

The re-assessment process is currently underway with appropriate engagement from relevant parts of the organisation.

Submission is required by the end of November with it being a requirement that the submission has been considered by Board prior.

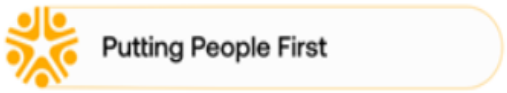
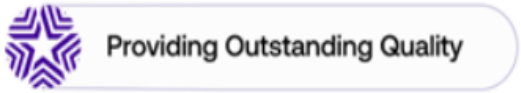
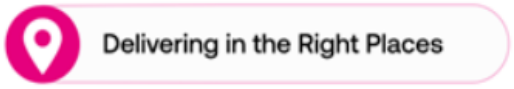
The self-assessment is scheduled for Board consideration at its meeting on the 26th November. A discussion on the emerging assessment is also scheduled for November's Finance and Performance committee.

Recommendation:

The Board is requested to:

(a) **Note** the progress being made across the Strategy, Planning and Partnerships and Commissioning work programmes.

(b) **Note** the key delivery risks and external dependencies set out in the report; and support continued alignment of annual planning, commissioning intentions and strategic portfolio delivery.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please place an "X" in the below boxes as relevant.*			
1.  **Click the objective above to view more detail.**	x	 2. **Click the objective above to view more detail.**	x
3.  **Click the objective above to view more detail.**	x	 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		No		

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:

Report Title:	Targeted Intervention Update				Agenda Item No:	6.8	
Meeting:	CAV Board		Public	X	Meeting Date:	24.09.26	
			Private				
Status	Assurance	X	Approval		Information/Noting		
Lead Executive:	Executive Director of Strategy, Planning and Partnerships						
Report Author:	Head of Strategic Planning						

Main Report
Background and Current Situation:

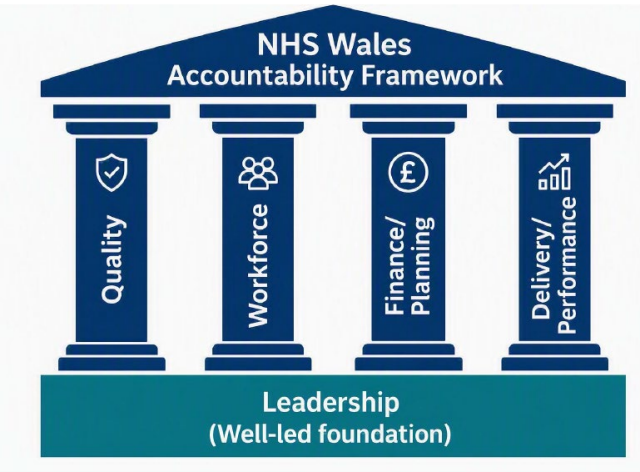
Purpose

The purpose of this report is to update on;

- The Independent Assessors recent report on the organisation,
- The Health Boards current position against its quantifiable de-escalation requirements across the Leadership foundation domain and four accountability pillars
- Feedback arising from the Mid-Year Accountability Review and third Escalation Board meeting.

Background and Situation

The All-Wales accountability framework sets out how the Health Boards level of escalation is managed- principally through gaining assurance (or not) on four pillars and a foundational domain (as shown below) with a specific number of de-escalation criteria mapped to each.



Assessment

Recent independent assessment

Two Independent Assessors were appointed by NHS Wales Performance and Improvement (NHSP&I) in March 2026 to identify the underlying organisational factors contributing to the Health Board's escalation position- their report was published on 7 August 2026. The report centred on four areas for improvement: governance; culture; leadership and management; and planning and delivery.

The report made 15 recommendations focused on strengthening the Health Board's organisational arrangements and improvement approach.

All recommendations have been reviewed against the Health Board's emerging Integrated Improvement Plan (IIP), identifying areas for improvement. Where recommendations are only partially addressed or are not clearly reflected within existing programmes, further work is being undertaken to determine whether current activity should be strengthened or additional actions introduced.

This work is supporting the follow-on discussions subsequently held with NHSP&I who have set the expectation that a robust and finalised interim IIP is in place by the 31 October which specifically sets out the organisations focus of attention for the remainder of 26-27 so that clear assurance on the issues raised within the report can be actively monitored and understood.

Subject to NHSP&I confirmation this interim IIP will be organised into a series of chapters aligned to the revised accountability framework described above.

The current quantifiable position across the Leadership foundation domain and four accountability pillars

Annex 1 sets out the current detailed position against each quantitative de-escalation measures.

The headline position across the Leadership foundation domain and four accountability pillars are summarised below

Foundation Domain: Leadership (Well Led)

The Health Board is focused on rebuilding confidence by strengthening leadership, governance, accountability and the connection between planning and delivery.

At board level, we have already performed a self-assessment against the well-led framework in May, to produce a baseline position. We will repeat this exercise routinely to assure ourselves and track progress. The exec team have met for the first of a series of in person developments days, agreeing a set of rules that they will collectively follow, to improve how they work together and support the organisation to become more successful.

The senior leadership team, being the most senior decision-making body below the board, has been redesigned to make it more effective, and focussed on evidence-based decision making. We are holding a wider leadership event in person in early October, to ensure we all understand our improvement plan, take collective ownership of it, and understand our role in delivering it.

To improve our clinical and patient representation at board meetings, we have established a new Healthcare Professionals' Forum (HPF) and revamped our Stakeholder Reference Group (SRG); the chair of both groups will be an associate member of the Board. The HPF will bring together clinical and professional perspectives from across the organisation, providing a balanced, multidisciplinary perspective on healthcare strategy, service delivery, service improvement and transformation to inform Board-level decision-making. The SRG, renamed "Shaping Our Future Wellbeing Collaborative", has been updated following a

review to ensure the membership is representative of the communities we serve, and strengthen our approach to service and strategic change.

We have redesigned the organisational risk framework and a new Corporate Risk Register developed. Clinical engagement continues to be strengthened through Clinical Board leadership structures and professional forums. A revised Strategic Leadership Team model has been developed to bring Executive Directors and Clinical Board Directors together with clearer collective ownership of priorities. The co-designed Future Operating Model is the organisation's primary response to the themes identified through reviews and engagement, with the focus now on planning for implementation, governance and delivery.

Quality

Quality remains a key organisational priority, with a focus on reducing avoidable harm, improving patient outcomes and strengthening assurance. Challenges remain in infection prevention and control, never events and a number of high-risk services. Progress includes improvements in patient flow and length of stay, action to address patients lost to follow-up, strengthened controls and learning following never events, and improvements in mortality measures supported by more consistent review arrangements and improved clinical coding. Further work will focus on sustaining improvements in flow, reducing avoidable harm and strengthening the use of quality information and learning. Implementation of a robust Quality Management System remains a key priority to support more consistent oversight and improvement across the Health Board.

Workforce

Activity has focused on leadership and management capability, workforce planning, and workforce health, wellbeing and availability. This has included a Leadership Conference involving more than 270 leaders, a leadership and management capability assessment, increased workforce planning training, targeted attendance management action and Cultural Early Warning System (CEWS) initial dashboard development and pilot implementation. Focus during the next phase will be on embedding these improvements through implementation of leadership standards, the Manager Passport and capability assurance framework, alongside expansion of the Cultural Early Warning System (CEWS). Attendance management and wellbeing interventions will continue to be scaled up, with enhanced training capacity, targeted support in priority areas and development of a more data-led approach to workforce availability. Workforce controls are also supporting financial recovery and implementation of the Future Operating Model.

Finance and Planning

The Health Board continues to forecast an £86.5 million deficit. Month 5 reporting shows a financial trajectory to a £102 million deficit before the impact of additional actions, with the difference between the trajectory and forecast broadly reflecting the current £17.9 million shortfall against the core savings target of £42.5m. Enhanced action is being taken through twice-monthly turnaround meetings with each Clinical Board and workforce initiative targets

across operational areas. The pace of progress is not yet sufficient to fully de-risk the 2026/27 plan by 31 March 2027. External support to accelerate turnaround actions was therefore secured and commenced on 7 September 2026.

Delivery and Performance

The Health Board is making progress across several priority areas while recognising the significant performance challenges that remain. Planned Care has exceeded its year-end commitment on 104-week waits, supported by ongoing validation activity, with Stage 3 validation delivering performance 1,816 ahead of trajectory. Cancer performance has continued to show incremental improvement despite sustained growth in demand, and Urgent and Emergency Care maintained ambulance handover performance during significant operational pressure, including the summer heatwave business continuity incidents.

Diagnostic activity has increased but has not kept pace with changing demand, with workforce and infrastructure constraints continuing. Recovery schemes covering additional capacity, vetting and validation have been developed and, if approved and delivered in full, would reduce the number waiting over eight weeks to approximately 4,000 by the end of March 2027.

Positive improvement is also reported across the Population Health indicators. The gap to the Wales average for HPV vaccination has narrowed to 0.1%, access to smoking cessation services has increased over six consecutive quarters, and Cardiff and Vale has the highest percentage of healthy-weight children in Wales.

Feedback arising from the Mid-Year Accountability Review and third Escalation Board meeting.

The Health Board met with WG on 15 September 2026 for a Mid-Year Accountability / Escalation Board meeting. Due to the timing on the preparation and publication of this paper for Board a verbal update on the discussions / outcome of this meeting be given in Board.

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

Board received an extensive Targeted Intervention update at its development session on 27 August 2026. The current overall position remains consistent with that presented. This update is therefore intended to formally reaffirm the Health Board's response and position.

The next Escalation Board meeting will take place on the 19 November 2026. This will be chaired by the Cabinet Minister for Health and Care, with attendance from the Chair and representatives of the Independent Members.

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

Annex 1 - Targeted Intervention Data Pack (Sept 26)

Recommendations:

NOTE the UHBs current position performance position against its quantifiable de-escalation criteria.

NOTE working taking place in response to the independent assessors' 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		2. Providing Outstanding Quality	x
3. Delivering in the Right Places	x	4. Acting for the Future	x

Five Waves of Working (Sustainable Development Principles) considered: Please place an "x" in the below boxes where relevant									
Prevention	x	Long Term	x	Integration	x	Collaboration	x	Involvement	x

Quality Impact Assessment Completed? Please place an "x" in the below boxes where relevant				
Yes *(please include the complete QIA document)*	x	No *(please provide reasoning e.g. not required*		

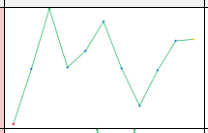
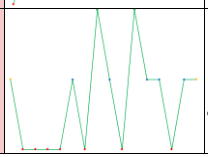
Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:

RAG Key

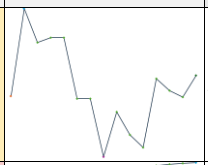
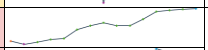
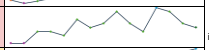
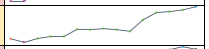
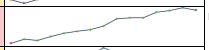
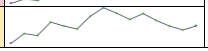
	Achieved the de-escalation requirement for two consecutive quarters
	Currently meeting the standard for the most recent reporting month
	Not achieving the de-escalation requirement.

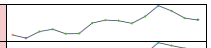
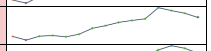
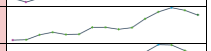
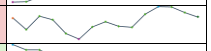
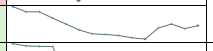
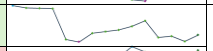
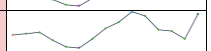
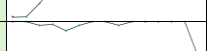
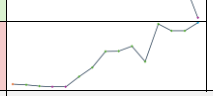
Pillar 1: Quality

De-Escalation Criteria		Measure	De-escalation Requirement	Apr-25	Apr-25 to May-25	Apr-25 to Jun-25	Apr-25 to Jul-25	Apr-25 to Aug-25	Apr-25 to Sep-25	Apr-25 to Oct-25	Apr-25 to Nov-25	Apr-25 to Dec-25	Apr-25 to Jan-26	Apr-25 to Feb-26	Apr-25 to Mar-26	Apr-26	Apr-26 to May-26	Apr-26 to Jun-26	Apr-26 to Jul-26	RAG	Comments
Infection	2) Number of cumulative C.difficile cases, hospital onset E.coli BSI and MRSA BSI cases to be in line with all-Wales average over two successive quarters.	Cumulative number of C.difficile infection cases	In line with all-Wales average for that month *(grey boxes all-Wales averages)*	17	34	48	69	80	106	118	132	148	165	179	186	17	26	44	61		The Health Board continues to focus on reducing C. difficile infections through active engagement with the C. difficile Collaborative, promotion of the Prevent C. difficile campaign, implementation of a C. difficile education tool and prompt isolation of suspected and confirmed cases. There have been eight fewer cases reported compared to the same period in 2025. The next phase of work is focused on continued rollout of the C. difficile education tool across clinical areas, ongoing staff engagement and monitoring uptake to support consistent application of best practice in prevention, diagnosis and management.
				16	*30*	*46*	*63*	*79*	*100*	*116*	*133*	*148*	*162*	*175*	*190*	*16*	*31*	*49*	*70*		
		Cumulative number of hospital onset E.coli BSI cases		3	8	17	23	28	31	41	44	48	56	60	64	5	13	21	33		There has been an increase of 10 hospital-onset E. coli cases compared to the same period in 2025. Actions include engagement with All Wales Urinary Tract Infection Management Groups, continued compliance with CSARO guidance, and audit of urinary catheter insertion and maintenance practices. Next steps include continued audit activity and development of an education tool to support improvements in urinary catheter management, UTI prevention and patient safety.
				5	*10*	*18*	*25*	*30*	*37*	*44*	*49*	*54*	*60*	*65*	*71*	*4*	*9*	*16*	*23*		
		Cumulative number of hospital onset MRSA BSI cases		2	2	2	3	4	5	5	7	7	8	8	8	2	2	2	3		There have been three hospital-onset MRSA bacteraemia cases recorded between April and July 2026, which is consistent with performance during the same period in 2025. Actions have included Executive review of hospital-onset bloodstream infection cases, increased Infection Prevention and Control audits of peripheral and central venous catheter insertion and maintenance bundles, and continued engagement with the All Wales ANTT Improvement Network. Next steps include continued audit activity and Executive review of each hospital-onset MRSA bacteraemia case to identify learning opportunities and ensure actions are implemented to reduce the risk of recurrence
				1	*1*	*2*	*2*	*2*	*2*	*3*	*4*	*4*	*5*	*5*	*5*	*1*	*1*	*1*	*2*		

		Measure	De-escalation Requirement	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	RAG	Trendline	Comments
Complaints	3) 65% of complaints to be closed within 30 working days (by date received) over two successive quarters.	% of PTR concerns settled in 30 working days (by date received)	65%	52.5%	60.6%	69.4%	60.8%	63.2%	67.5%	60.7%	55.2%	60.4%	64.7%	64.90%	*No data from March-26. See comments box for information*							**Note -** There is a data gap since March-26 as there is a need to clarify the de-escalation requirement for the TI Concerns metric. The current measure is 65% of concerns closed within 30 working days; however, following the introduction of the Listening to People Regulations on 1 April, it is unclear whether this will transition to 40% of concerns closed at early resolution to align with the Ministerial Key Delivery Expectation and corresponding updates to the Beacon dashboard.
Never Events	4) Sustained reduction in never events (by incident date) to be demonstrated over two successive quarters.	Number of never events (by incident date)	Sustained reduction	1	0	0	0	0	1	0	2	1	0	2	1	1	0	1	1			**Never Events:** Never Events remain one of the Health Board's highest quality risks. Improvement actions have focused on learning from perioperative and medication-related Never Events, including revised safety processes, strengthened medicines safety controls and targeted training and audit arrangements. Further work is planned through implementation of revised perioperative safety tools, rollout of associated education and audit resources, continued delivery of the Medicines Safety workstream and revision of scrub practitioner training to support a sustained reduction in incidents

Pillar 4 - Delivery/Performance

	Criteria	Measure	De-escalation Requirement	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	RAG	Trendline	Comments
Cancer	1) 60% performance maintained against the SCP target	% of patients starting first definitive cancer treatment within 62 days from point of suspicion	60.0%	61.0%	72.1%	67.8%	68.4%	68.4%	60.7%	60.7%	53.3%	59.0%	56.1%	54.5%	63.2%	61.7%	60.9%	63.6%			**Cancer:** Cancer performance has continued to show incremental improvement despite sustained growth in demand. The Health Board has achieved four consecutive months of over 60% compliance against the Single Cancer Pathway (SCP) standard, with June 2026 performance at 63.6%. Capacity gains, tumour-site specific interventions and strengthened demand and capacity management are being progressed to support recovery and achievement of the 75% SCP compliance ambition by March 2027
Planned Care	2) 100% of open outpatient pathways to be waiting less than 52 weeks.	% of open pathways waiting less than 52 weeks for a new outpatient appointment	100.0%	80.5%	79.6%	80.3%	81.0%	81.3%	83.9%	85.0%	85.9%	85.0%	85.0%	86.9%	89.1%	89.5%	89.8%	90.0%			**Planned Care:** Planned Care performance has continued to improve, with the Health Board exceeding its year-end commitment on 104-week waits and validation activity remains ahead of trajectory. Improvement actions are focused on outpatient transformation, including conversion of patients to SOS/PIFU pathways, creation of additional outpatient appointments through DNA overbooking, and active management of patients awaiting pre-operative assessment and treatment.
	3) 100% of open pathways to be waiting less than 104 weeks	% of open pathways waiting less than 104 weeks for referral to treatment	100.0%	98.8%	98.8%	99.1%	99.1%	99.0%	99.4%	99.2%	99.3%	99.6%	99.3%	99.1%	99.7%	99.6%	99.3%	99.2%			
	4) 80% of open pathways to be waiting less than 52 weeks.	% of open pathways are waiting less than 52 weeks for referral to treatment	80.0%	78.0%	77.3%	78.1%	78.5%	78.5%	80.0%	79.9%	80.1%	79.9%	79.6%	81.9%	83.4%	83.6%	83.9%	84.6%			
	5) 15% reduction in the number of patients delayed by 100% for their follow up appointment in 3 consecutive months (Based on baseline)	Number of patients waiting for a follow up outpatient appointment who are delayed by over 100%	14,415	21,758	22,853	22,503	23,473	24,346	24,869	25,248	26,146	28,065	28,267	28,268	29,682	30,091	30,870	30,235			
	6) 65% R1 ophthalmology patient pathways to be waiting within or no longer than 25% of their target date for an outpatient appointment.	% ophthalmology R1 patient pathways waiting within their clinical target date or within 25% beyond their clinical target date	65.0%	61.9%	63.9%	63.5%	66.2%	65.4%	64.8%	67.4%	69.1%	68.0%	66.7%	67.9%	66.5%	65.4%	64.6%	65.4%			

Diagnostics	7) 80% of patients waiting for a diagnostic test to be waiting less than 8 weeks.	% of patients waiting less than 8 weeks for diagnostic test	80.0%	42.4%	39.9%	45.2%	47.0%	43.4%	43.6%	52.0%	54.5%	53.9%	51.9%	57.3%	66.1%	61.8%	56.1%	54.5%			**Diagnostics** The diagnostic position remains challenging, reflecting increasing demand, significant changes in demand across cancer, urgent and inpatient pathways, and ongoing infrastructure and workforce constraints. Recovery schemes focused on additional capacity, vetting and validation have been developed to support improvement, although delivery of the recovery trajectory will be dependent on these schemes being supported and implemented in full
	8) 80% of patients waiting for a diagnostic endoscopy to be waiting less than 8 weeks.	% patients waiting less than 8 weeks for diagnostic test - diagnostic endoscopy	80.0%	17.6%	13.3%	18.0%	18.7%	17.4%	20.3%	27.7%	30.8%	34.7%	37.2%	39.3%	52.8%	49.2%	46.2%	40.9%			
	9) 80% of patients waiting for a NOUS and non-cardiac MRI to be waiting less than 8 weeks.	% patients waiting less than 8 weeks for diagnostic test - NOUS	80.0%	33.9%	34.3%	38.2%	40.4%	38.6%	38.8%	44.4%	44.5%	42.8%	44.0%	51.3%	57.0%	60.5%	58.3%	54.4%			
		% patients waiting less than 8 weeks for diagnostic test - non cardiac MRI	80.0%	66.3%	56.2%	68.0%	64.9%	52.6%	47.7%	58.6%	63.2%	59.2%	58.3%	69.8%	76.6%	76.4%	71.4%	67.4%			
	10) 85% of patients waiting for therapies to be waiting less than 14 weeks.	% patients waiting less than 14 weeks for therapy	85.0%	95.8%	94.9%	94.9%	93.8%	92.8%	91.8%	91.1%	91.0%	90.8%	90.4%	90.2%	92.1%	92.8%	92.0%	92.5%			
UEC	1) 30% reduction in ambulance handovers over 45 minutes and maintained for three months	Ambulance handovers over 45 minutes	428	598	565	561	554	111	73	199	224	249	300	380	141	157	81	173			**UEC:** UEC performance remains challenging, with demand and admissions continuing to rise faster than flow gains. Improvements have been delivered in discharge volume, emergency length of stay and pathways of care delay bed occupancy, while performance against the W45 ambulance handover measure has been maintained despite significant operational pressures. However, 12-hour waits remain above the de-escalation requirement. Planned actions are focused on scaling ward flow, frailty services, same day emergency care and community alternatives to support further improvement ahead of winter
	2) Continuous improvement towards no-more than 7% of patients waiting over 12 hours at each individual site and across the health board.	% of patients waiting 12 hours or more in ED - Cardiff & Vale UHB	7.0%	7.7%	7.8%	7.8%	7.2%	6.8%	6.7%	7.3%	8.2%	8.7%	9.5%	9.1%	8.0%	7.9%	7.4%	9.2%			
		% of patients waiting 12 hours or more in ED - UHW	7.0%	8.1%	8.2%	8.3%	7.7%	7.2%	7.1%	7.8%	8.6%	9.1%	9.9%	9.6%	8.5%	8.4%	7.8%	9.7%			
	3) Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60-minutes.	Median time from arrival at ED to assessment by a clinical decision maker (mins)	60	63	64	68	65	71	73	82	78	73	64	71	65	66	67	67			
	4) Continuous reduction in delayed pathways of 5% (based on agreed baseline)	Number of pathways of care delays	128	150	139	155	149	176	176	177	187	158	171	164	156	155	154	152.00			
Mental Health	1) 80% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral.	% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral (>= 18 years)	80.0%	29.6%	30.4%	58.0%	92.4%	92.5%	95.9%	100.0%	99.9%	100.0%	100.0%	100.0%	99.5%	98.5%	100.0%	99.5%			**Mental Health:** Mental Health Sustained performance above the de-escalation requirement for LPMHSS assessments within 28 days (11 months) and therapy started within 28 days (14 months). Mental Health Care and Treatment Plans performance has improved over the last year but remains 7.8% below the de-escalation requirement.
	2) 65% of therapeutic interventions started within 28 days following an assessment by LPMHSS.	% of therapeutic interventions started within 28 days following an assessment by LPMHSS (>= 18 years)	65.0%	100.0%	100.0%	99.6%	99.7%	99.0%	99.6%	100.0%	100.0%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%			
	3) 80% of HB residents in receipt of secondary mental health services who have a valid care and treatment plan.	% of HB residents in receipt of secondary mental health services who have a valid care and treatment plan (>= 18 years)	80.0%	57.2%	57.1%	56.8%	56.6%	56.6%	59.1%	61.3%	65.2%	65.3%	66.5%	62.7%	71.9%	70.2%	70.2%	72.2%			

		Measure	De-escalation Requirement						Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27	RAG	Comments
Vaccination	1) Percentage of children up to date with scheduled vaccinations by age 5 to be in line with the all-Wales average	% of children up to date with scheduled vaccinations by age 5 to be in line with all Wales average	In line with all-Wales average for that month *(grey boxes all-Wales averages)*						85.6%	83.6%	85.3%	85.0%	83.6%		Work ongoing to close the gap to Wales average (baseline Q3 24/25)
									87.7%	*88.0%*	*87.5%*	*87.5%*	*87.2%*		
	2) HPV vaccine uptake rate for children by the age of 15 to be in line with all Wales average.	% of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15							71.3%	72.6%	74.9%	75.6%	76.8%		Gap to the Wales average for the HPV vaccine has narrowed to 0.1% of Welsh Average, from 5.2% below the average six quarters ago
									74.1%	*74.9%*	*75.6%*	*76.2%*	*76.9%*		

		Measure	De-escalation Requirement	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27	RAG	Comments
Smoking	3) Percentage of adult smokers who make a quit attempt via smoking cessation services towards the target compliance over the 12-month period measure.	% of adult smokers who make a quit attempt via smoking cessation services	7.5%	0.80%	1.60%	2.51%	3.39%	1%		Performance in Q1 2026/27 (1%) continues to improve on performance in Q1 2025/26 (0.8%). During this quarter 381 smokers made a quit attempt, an increase.

Report Title:	Welsh Gender Service Escalation				Agenda Item No:	6.9	
Meeting:	Public		Public	x	Meeting Date:	24/09/26	
			Private				
Status	Assurance		Approval		Information/Noting		X
Lead Executive Title:	Executive Medical Director						
Report Author Title:	Executive Medical Director						

Main Report
Background and Current Situation:

Since the NHS Wales Joint Commissioning Committee (NWJCC) requested the temporary pause of referrals for gender affirming surgery, surgical assessments and scheduled surgery through the Welsh Gender Service, Cardiff and Vale University Health Board has continued to work closely with partners to provide assurance, support affected patients and maintain confidence in the safe delivery of care and the information provided to patients and stakeholders.

The pause applies specifically to the gender affirming surgery pathway. The pause does not affect patients who have already had surgery and require follow-up care, those who are midway through a series of surgical procedures, treatment for complications, or other clinically necessary aftercare.

Other services provided through the Welsh Gender Service continue, including hormone therapy support, endocrine review, psychological support, speech and language therapy, and fertility preservation and treatment services.

Patients with scheduled appointments have been asked to continue to attend unless they are contacted directly and advised otherwise.

The Health Board continues to recognise the uncertainty and distress experienced by patients, families, staff and the wider community. Ongoing communication activity has focused on providing clear and factual information, responding to concerns, and reinforcing the organisation's commitment to safe, evidence based and compassionate care

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

Communications activity

Patients

- Direct correspondence issued to all 451 affected patients identified across the surgical pathway, including signposting to single point of contact for queries or psychological support, as well as Third Sector support.
- Continued publication of regular service updates and frequently asked questions to provide clarity on the pause and the care that remains available.
- A single point of contact established through the Concerns Team to coordinate patient enquiries and support requests. More than 115 individual enquiries have received personalised responses, predominantly from patients seeking clarification or reassurance.

- Key messaging has emphasised that patients with existing appointments should continue to attend unless advised otherwise and that support services remain available throughout the review process.
- Patient concerns and feedback continue to be gathered and used to shape future communications and engagement activity. Website information includes public updates, generic patient letter, frequently asked questions and signposting to mental health, advocacy and LGBTQ+ support organisations.

Staff

- Information has been provided to Welsh Gender Service teams, senior leaders, primary care colleagues and operational managers to ensure consistent messaging and support for staff handling patient enquiries.
- Communications have focused on maintaining staff confidence, reinforcing the organisation's commitment to safe care, and ensuring colleagues understand the scope of the pause and the ongoing review process.

Public

- The Health Board has issued regular public updates through its website and digital channels to ensure accurate information is available and accessible.
- Media enquiries have been managed proactively with an emphasis on transparency, patient safety and the continuation of wider gender care services.
- Public messaging has focused on explaining the reasons for the review, correcting misinformation where necessary and reassuring the public that the review is intended to support safe, high-quality care.

Stakeholders

- Ongoing liaison has taken place with the NWJCC, Welsh Government officials, partner Health Boards, professional bodies and representative organisations.
- Stakeholder communications have focused on maintaining awareness of developments, providing consistent information and supporting constructive engagement throughout the review process.
- The Health Board continues to monitor stakeholder feedback and emerging issues to inform communications planning and operational management.

To demonstrate the level of interest, here is an outline of how many times people have viewed the updates on the Health Board website:

Welsh Gender Service web page (since 28 August)	2,319
Welsh Gender Service update – 28 August	9,401
Welsh Gender Service update – 3 September	1,012
Frequently asked questions web page	1,278
Welsh Gender Service update – 11 September	890

Data collected: 17/09/2026

Operational update

The organisation continues to prepare for and support the Independent Clinical Review commissioned in relation to the Welsh Gender Service surgical pathway. Activity is being

coordinated across clinical, operational, governance and communications functions to ensure the review team has timely access to the information and documentation if required.

Historically, the surgical waiting list has been maintained by Arden and GEM Commissioning Support Unit (CSU) on behalf of Gender Services across the UK. However, following recent learning and service review findings, the surgical waiting list will now be maintained locally by the Welsh Gender Service, alongside the centrally held list.

Further clarification and agreement will be required regarding the respective responsibilities and expectations of commissioners, providers, and Arden and GEM CSU. These arrangements will be considered as part of the broader review of service provision and future commissioning and governance structures.

Next steps

Over the coming weeks, the Health Board will:

- Continue to publish regular updates and maintain open communication with patients, staff and stakeholders.
- Support the Independent Clinical Review and associated assurance processes.
- Monitor patient, staff, stakeholder and media sentiment and respond to emerging issues.
- Develop communications plans to support the publication of review findings and recommendations.
- Work with the NWJCC and partners to support the safe and timely progression of assurance activity and any subsequent service improvement actions.

The overall communications objective remains to provide clear, compassionate and transparent information while supporting patients affected by the pause and maintaining confidence in the Health Board's commitment to safe, high quality and person-centred care.

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

None

Recommendations:

a) The Board is asked to note the actions undertaken by Cardiff and Vale University Health Board following the temporary pause to the gender affirming surgery pathway.
b) The Board is asked to note the ongoing communication and support arrangements in place for affected patients, staff and stakeholders.
c) The Board is asked to note the Health Board's support for the Independent Clinical Review and associated assurance processes.

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		2. Providing Outstanding Quality	X
3. Delivering in the Right Places		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	X	Integration		Collaboration		Involvement	

Quality Impact Assessment Completed? Please place an “x” in the below boxes where relevant				
Yes	X	No		

Impact Assessment
Please place an “x” in the below boxes where relevant

Risk: Yes

Yes - see safety section

Safety: Yes

The temporary pause to referrals, surgical assessments and scheduled gender affirming surgery has the potential to impact patient wellbeing and may contribute to increased anxiety and distress for affected individuals awaiting treatment. The Health Board continues to maintain oversight of associated risks through regular review arrangements with the Welsh Gender Service, Medicine Clinical Board, Executive Team and NHS Wales Joint Commissioning Committee. Wider Welsh Gender Service functions remain operational and patients requiring clinically necessary ongoing care, follow-up treatment or management of complications continue to receive support. Patient safety remains a key consideration within all assurance and review processes.

Financial: No

The Health Board has reimbursed non-refundable travel and accommodation costs for people affected by the pause.

Workforce: Yes

The temporary pause and associated public, political and media scrutiny have the potential to affect staff wellbeing, morale and confidence, particularly for colleagues working within the Welsh Gender Service and supporting functions. The Health Board has maintained regular communication with staff, reinforced its commitment to safe, evidence-based and compassionate care, and continues to provide managerial and professional support to colleagues. Workforce impacts are being monitored through established governance arrangements, with any emerging concerns escalated and addressed as appropriate. There has also been impact upon the Concerns and Communications teams who have had to prioritise the support for this work and support.

Legal: No

Reputational: Yes
Given the significant public, stakeholder and media interest in the Welsh Gender Service, there is an ongoing reputational risk associated with public confidence, patient experience and external scrutiny. This risk is being mitigated through transparent communication, proactive engagement with stakeholders, support for the Independent Clinical Review, and the publication of regular updates.
Socio Economic: Yes
The temporary pause has the potential to have a disproportionate impact on some patients experiencing socio-economic disadvantage, particularly where additional travel, support needs, impacts on wellbeing, or prolonged uncertainty are experienced. The Health Board has sought to minimise these impacts through direct communication, accessible information, and continued access to existing support services. Ongoing consideration is being given to the needs of affected patients throughout the review process. We are reimbursing travel costs for those affected.
Equality & Health: Yes
Given the significant public, stakeholder and media interest in the Welsh Gender Service, there is an ongoing reputational risk associated with public confidence, patient experience and external scrutiny. This risk is being mitigated through transparent communication, proactive engagement with stakeholders, support for the Independent Clinical Review, and the publication of regular updates
Decarbonisation: No
Welsh Language: No
The report does not introduce changes to service provision or patient access arrangements. Communications issued by the Health Board continue to comply with Welsh Language Standards and support the principles of *More Than Just Words*. Information is made available bilingually where appropriate to ensure patients can access information in their preferred language.

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

Report Title:	Integrated Performance Report					Agenda Item No:	6.10
Meeting:	Board		Public	X		Meeting Date:	24.09.26
			Private				
Status	Assurance	X	Approval			Information/Noting	
Lead Executive Title:	Chief Operating Officer						
Report Author Title:	Head of Performance						

Main Report

Background and Current Situation:

The Integrated Performance Report provides a collective overview of key performance metrics within Cardiff and Vale University Health Board. The report covers six domains, each with a nominated Executive lead, these are: Finance, Operational Performance, Quality, People and Culture, Public Health and Digital.

September 2026 represents the second month of a revised presentation of metrics within the IPR. Following recent Internal Audit findings which highlighting shortcomings in the previous presentation of the IPR, and in line with developing NHS Wales guidance, the information within the IPR is moving to being presented through Statistical Process Control (SPC) charts. In time, this approach will help to improve consistency of reporting, allow clearer identification of trends and allow improved tracking of performance. Correct application of SPC charts can improve understanding of how processes and performance have changed overtime, providing Board with a richer opportunity for discussion on underlying causes.

This approach will continue to iterate based on feedback from the Board and Committees.

The IPR is included as an appendix to this paper, comprising Executive Summary and measures for each executive area, with associated chart, narrative, concerns and actions.

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

- The IPR is presented in a revised format using SPC charts where appropriate
- This is a part of wider, iterative, improvements in performance management and reporting
- There are some known further development requirements in the application of SPC rules, and use of SPC charts, which will change the measure indicators in future versions

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

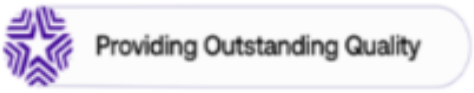
Integrated Performance Report – Executive Narrative and Performance Measures

Recommendations:

a) Board is requested to NOTE the revised approach and ongoing developments to the Integrated Performance Report
b) NOTE the position against key organisational performance indicators for 2026-27 and the update against the Operational Plan programmes.

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. 		2. 	
3. 		4. 	

Five Waves of Working (Sustainable Development Principles) considered: Please place an "x" in the below boxes where relevant									
Prevention		Long Term	x	Integration	x	Collaboration		Involvement	

Quality Impact Assessment Completed? Please place an "x" in the below boxes where relevant				
Yes		No X		Not required X

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:

Executive Narrative - Quality and Safety

Reporting Month: Sep 2026

Executive Summary

There has been a significant focus on the management of nationally reportable incidents with a significant reduction in overdue reports, despite this the majority of Clinical Boards are not yet meeting their reduction trajectory which is focused on eradicating avoidable overdue reports by February 2027.

The UHB reported 15 nationally reportable incidents in August 2026. The most common NRI theme relates to perinatal mortality cases, each of these cases is subject to a multi professional mortality review that is part of a national review and in the majority of cases demonstrate that the care provided was good and did not impact on the outcome. Where improvement work has been informed by the mortality reviews this is generally focused on standardisation of practice through the development or update of policy and procedure with associated audit.

Pressure damage is the next highest category, and pressure damage impacts around 9% of inpatient. Work is being undertaken to develop a training programme and the development of a skin advocate role on the wards to improve knowledge and awareness of pressure damage grading and prevention. The UHB is going to strengthen the process around reporting of lower severity pressure damage and to apply the same level of scrutiny as it currently undertaken around the more severe cases to support a preventative approach.

The organisation reported one never Event in July 2025 that related to the informed consent process rather than sequential peri-operative theatre checks and no Never Events were reported in August.

The main themes from patient experience feedback relate to communication, including the provision of timely updates, clarity of information, and continuity of communication throughout the patient journey. Feedback also highlighted concerns regarding waiting times and service coordination, particularly where patients required input from multiple teams.

Risk adjusted mortality, rolling annual stroke mortality and rolling hip fracture mortality are all continuing to reduce and reflecting the work underway to improve the clinical coding position. Furthermore the health board is now able to access Standardised Hospital Mortality Index (SHMI). SHMI which measures actual deaths of individuals up to 30 days post discharge and includes the deaths of patients receiving palliative care and compares against a denominator of all deaths calculated from all inpatient admissions and uses variables including age, sex admission method and comorbidities to predict mortality. SHMI was measured as 88 in July 2026 which is below the expected measure of 100 and is likely to reflect delays in coding.
Complaint themes continue to focus on communication, waiting times, access to services and care coordination. Learning from complaints and patient feedback continues to inform service improvement initiatives.

The Health Board's infection prevention and control performance presents a mixed picture against Welsh Government reduction targets. Positive progress has been achieved in reducing hospital-onset Pseudomonas aeruginosa bacteraemia, E. coli bacteraemia and MSSA, with all three measures performing better than the Health Board's internal trajectory at the midpoint of the improvement period. However, performance remains challenged in relation to hospital-onset Klebsiella bacteraemia, C. difficile infection and MRSA. The Health Board exceeded its internal target for Klebsiella bacteraemia, reporting 56 cases against a target of 45, while C. difficile cases also marginally exceeded the midpoint target despite sustained improvement efforts. MRSA rates have increased compared with the previous year, with the organisation reporting the third highest MRSA rate in Wales. Root cause analyses undertaken for bloodstream infection cases have generally not identified deficiencies in care, with cases largely assessed as unavoidable. Nevertheless, variation in compliance with key i

Executive Actions and Owners

Focused work to address delays in nationally reportable incident (NRI) and patient safety incidents is resulting in improvements . 7% of NRIs are open for over 12 months which is the lowest proportion of all health organisations in Wales. There are 65 NRIS under review in the UHB compared with 120 in February 2025. There are just over 5000 patient safety incidents under investigation at present compared with 8000 in February 2025 which a very significant reduction in the volume that subject to delay prior to management review.

An August 2026 WHO Surgical Safety Checklist audit across four theatre suites reviewed 11 patient episodes and found consistently high compliance, with Team Brief, Sign In, Time Out, "happy to proceed" check and Sign Out completed and documented in all audited cases, providing positive assurance that the checklist process is well embed.
There is local work underway between stroke services and the clinical coding team to improve the coding accuracy. The Surgery Clinical Board met with trauma and orthopaedics to review hip fracture mortality, it was noted that there is further work to focus on the accurate recording of ASA, a measure of pre-anaesthetic medical condition and acuity.
Learning from patient experience feedback continues to be reviewed through governance arrangements and used to inform quality improvement initiatives, with a particular focus on strengthening communication, patient engagement and coordination of care.

The concerns team is focusing on achieving and sustaining Early Resolution performance above target.
Continued thematic analysis of complaints and patient feedback to identify emerging trends is underway to inform the clinical board response and actions.
There is ongoing monitoring of patient satisfaction trends to evaluate the impact of improvement activities through established governance arrangements including targeted improvement actions relating to communication and access to services.

A range of improvement initiatives are underway across the organisation to address areas of underperformance and support delivery of Welsh Government infection reduction expectations. The Infection Prevention and Control team continues to review all root cause analyses for bloodstream infections to identify recurring themes that can inform targeted education and training programmes. Enhanced auditing programmes have been implemented for urinary catheter insertion and maintenance, as well as peripheral vascular catheter and central venous catheter insertion and care bundles, with audit findings being used to reinforce required standards within clinical areas. Additional education and training are being delivered to improve compliance with urinary catheter care and ANTT practices, while national work to improve ESR functionality is expected to strengthen monitoring of staff training compliance. Significant improvement work has also been undertaken in response to increased C. difficile cases, particularly within paediatric oncology, where targeted interventions focusing on sampling techniques, isolation practices, antimicrobial review and environmental decontamination have been associated with a substantial reduction in cases. An organisation-wide C. difficile improvement plan has been developed, supported by Clinical Board-level action plans, and an educational resource has been made available to staff through SharePoint. For MRSA, executive-led case review processes have been introduced, providing enhanced scrutiny of root cause analyses and strengthening organisational oversight of improvement actions

Previous Months Executive Actions and Owners

No previous month actions recorded

Executive Narrative - Digital and Health Intelligence

Reporting Month: Sep 2026

Executive Summary

Key highlights

• Laboratory Info System (LIMS2) Tranche 3 (Microbiology) went live on 24/08/26
• LIMS2 Tranche 4 (Blood Sciences) is scheduled to go live in Nov 26
• Digital Priorities Investment Funding secured for the Connecting Care programme to support the procurement of a replacement patient record system for community and mental health services.
• A further 400 community access laptops deployed to support a mobile, non-acute workforce.
• Amazon Web Services Secure Landing Zone is now live for parallel running of the All-Wales Medical Genomics workload.

Digital Operations
Windows 11 migration is progressing well, with under 400 active devices remaining ahead of the October 2026 deadline.

Windows 11
• 98% of devices are now running Windows 11.
• The Win11 project team is actively assisting Pathology IT to replace/update outstanding lab-based Win10 devices.
• Under 250 devices remain on the exclusion list due to software incompatibility and require Windows 10 extended support for 2026–27.

Wi-Fi
• The project is now focussed on the 'non-inpatient ePMA areas' (outpatient areas).
• Additional/replacement Wi-Fi Access Points - 100% of all identified Inpatient areas now complete with 36% of all Outpatient areas complete (includes the areas where e-prescribing is being implemented and the non-clinical areas where staff reliant on adequate Wi-Fi (eg CEF staff).

Digital Eyecare
• The OpenEyes EPR, hosted by CAVUHB, is now deployed across most Welsh Health Boards, with widespread use in CAVUHB, SBUHB and ABUHB.
• The electronic referral system to support digital eye care is live and in use.
• Discussions on the future contractual arrangements are underway with Welsh Government and Digital Health Care Wales.

Amazon Web Services (AWS) Secure Landing Zone
• The AWS Steering Group has approved a “Go” decision for parallel running of workloads in AWS.
• A strategic PSBA Cloud Connection procured to improve resilience and performance of data transit between CAVUHB locations and AWS.

Business Intelligence
The BI Team has released an EU dashboard in Power BI that visualises the UEC pathway and subsequent phases will bring in data from Pathology, Radiology and Health Roster. A new dashboard for Paediatric Integrated clinics has been set up with automated data refresh for release in early October.

Executive Actions and Owners

Previous Months Executive Actions and Owners

No previous month actions recorded

Executive Summary

HEALTHY WEIGHT
Good Food and Movement Implementation Plan 2026-2028 finalised. Cardiff Facilities audit is complete, with findings shared with Cardiff Leadership and Enabling Change Group. Cardiff Community Health Development workshop held in July 2026 to explore the potential of developing a more strategic approach to community health development for Good Food and Movement. Cardiff and Vale Good Food and Movement Schools Group met in July . Communication Strategy developed for Good Food and Movement.

SMOKING CESSATION
Smoking prevention – During school holiday period, service staff engaged in Summer Food and Fun programme to offer raise awareness and provide advice to children and young people on smoking and vaping risks.
Smoking cessation – New in-person Help Me Quit clinic opened at Pre-operative Assessment Clinic UHW. First phase implementation of Allen Carr Easyway intervention completed (reached and supported 100 smokers to quit).
Smoke-free places – Hospital site patrols project concluded; 1380 incidents of patients, staff and visitors smoking on hospital sites recorded between Nov 27 and Jul 26. Update presented to CAVUHB Quality Committee.

WOMEN'S HEALTH HUBS
Commissioned Women's Health Needs Assessment (focusing on contraception, menopause and menstrual health) has been completed.
Exception: Non-recurrent 26/27 funding for Women's Health Plan work from Welsh Government has not yet been agreed.
Exception action: Meeting planned with Welsh Government, Health Board Executive Director of Planning (or representative) and Finance lead as requested by Welsh Government (date tbc)

HEALTH PROTECTION
Work progresses on the review of key documents relating to health protection. The CAVUHB Pandemic Plan is being aligned with existing corpoate documents.

Executive Actions and Owners

IMMUNISATIONS
Up to date at age 5:
- Visits arranged with 15 GP practices identified as a priority for action in improving the rates of vaccination in children to bring them up to date by age 5. Two visits taken place to date and both practices are taking up the offer of extra capacity from our health protection surge team to contact the parents of children in this age group outstanding vaccinations.
- Lead: Anna Howells, Consultant in Public Health
HPV by age 15 (& other school-based vaccinations):
- Schools invited to identify vaccination champions and engage in a task and finish group to revise the model of school engagement in vaccination programmes. New model to be agreed and in place by 31 December 2026.
- Lead: Emma Davies-McIntosh, Principal Public Health Practitioner

HEALTHY WEIGHT
Vale Facilities audit is underway and near completion (being undertaken by Sporting Constructs)

SMOKING CESSATION
Smoking prevention – Work carried out to engage and recruit more schools to the Smoke-Free Ambassador Scheme (to gather pace after school Summer break).
Smoking cessation – Help Me Quit 'Hospital' service staff are supporting Help Me Quit 'Community' service in order to enhance service integration and smooth the transition between services on hospital discharge for smokers being supported to quit.
Smoke-free places – SOP developed to underpin Health Board No Smoking and Smoke-Free Environment Policy (co-produced by Public Health and People Services); describes actions that line managers can take to manage issues of staff non-compliance with policy.

HEALTH PROTECTION
In conjunction with the Department of Sexual Health, the Public Health Team have submitted two pieces of work to Welsh Government in August. Firstly, the Chief Medical Officer asked all health boards for a comprehensive summary of sexual health services provided, trends in demand and challenges. In addition, Welsh Government asked for an assessment of activity taken in Cardiff and Vale towards the Wales HIV elimination action plan.

Previous Months Executive Actions and Owners

No previous month actions recorded

Executive Summary

The UHB's financial plan of a £86.5m deficit was noted by the Board but not approved due to failure to meet statutory obligations.

In response to feedback from the Welsh Government, the Health Board wrote on 29 May 2026 confirming its intention to de-risk the financial plan by the end of Quarter 2.

At Month 5:

• The reported year to date position is am overspend of £43.1m with a year end planning deficit of £86.5m.
• There is an urgent need to de-risk the £86.5m deficit plan.
• An adverse year to date variance of £7.1m is reported against plan, driven by a £9.6m savings deficit, partially offset by an operational surplus against plan of (£2.5m).
• Schemes are identified to deliver the core savings target of £42.5m. Of these, £24.6m are assessed as either green or amber rated. However, there remains a significant delivery risk associated with the £20.0m of red-rated schemes. Further work is being undertaken with JCC to identify opportunities to achieve the remaining £5.1m required to deliver the additional 2% JCC efficiency target.
• Delivery of the deficit plan is contingent on delivery of a full savings programme and confirmation of all expected income streams.
• There are £62.5m of outstanding resource limit allocations and in due course the UHB expects to seek Finance Committee and Board approval to request £86.5m strategic cash support from Welsh Government to support the planned deficit.

Executive Actions and Owners

Progress in developing and implementing additional savings plans must accelerate to ensure the UHB can achieve its planning deficit target of £86.5m.

Previous Months Executive Actions and Owners

Progress in developing and implementing additional savings plans must accelerate to ensure that the UHB can achieve its planning target of £86.547m

Executive Narrative - People and Culture

Reporting Month: Sep 2026

Executive Summary

Overall performance across the People & Culture portfolio remains mixed, with positive and improving performance across a number of workforce indicators, but significant residual risks relating to sickness absence, bank expenditure, agency expenditure and workforce affordability.

Workforce turnover remains within the expected range at 7.7% and has continued to reduce month-on-month over the last 12 months, indicating improved workforce stability. Values Based Appraisal, Fire Safety Training and Statutory and Mandatory Training compliance have also continued to improve. However, all three measures remain below the Health Board's target of 85%, and targeted improvement activity remains in place.

Temporary staffing expenditure continues to present a material financial risk. Bank expenditure for April to August was £23.087m, approximately £4.808m above the five-month ceiling required to deliver the 10% reduction target and 26.3% higher than the same period last year. August bank expenditure increased to £5.116m, approximately £1.460m above the monthly ceiling. Based on the current forecast methodology, full-year bank expenditure is projected to reach £55.410m, approximately £11.539m above the annual ceiling.

Agency expenditure shows a more positive recent trajectory. Expenditure for April to August was £2.392m, representing a reduction of 4.5% compared with the same period last year. Spend in July and August was below the monthly ceiling required to deliver the 30% reduction target. However, earlier overspending means that year-to-date expenditure remains approximately £522k above trajectory, and the current full-year projection of £5.741m is approximately £1.254m above the annual ceiling. Sustained monthly expenditure at or below the ceiling will be required, alongside further recovery action, if the year-end gap is to be reduced.

Sickness absence also remains above the organisational target, with in-month absence at 6.1% and 12-month cumulative absence at 6.39% against the 5.5% target. This continues to affect workforce availability and service resilience and may contribute to the requirement for temporary staffing.

Workforce governance and inclusion measures continue to require attention. Medical job plan compliance remains below target and, while equality monitoring data completeness is improving, several indicators remain below the expected standard. Improvement plans are in place and are being monitored through established governance arrangements.

Executive Actions and Owners

Require each Clinical Board to produce a bank expenditure recovery plan, identifying the services, staff groups and underlying demand drivers responsible for the year-to-date variance.
Introduce weekly scrutiny of high-cost bank and agency usage, including long-term recurring bookings, enhanced rates, off-framework agency use and shifts requested outside agreed establishment.
Replace the current flat projection for September to March with a bottom-up forecast by Clinical Board, service and staff group, reconciled to finance, workforce plans and anticipated seasonal demand.
Convert recurring temporary staffing requirements to substantive or lower-cost capacity where this is affordable, sustainable and consistent with establishment controls.
Maintain agency expenditure at or below the monthly ceiling of approximately £374k, with additional recovery action to address the year-to-date overspend.
Strengthen controls over bank expenditure, supported by a clear monthly recovery trajectory towards the annual ceiling of £43.871m.
Monitor safe staffing, quality, access, workforce wellbeing and substantive pay alongside financial performance to ensure that cost reductions do not create unintended operational or workforce risks.

Previous Months Executive Actions and Owners

No previous month actions recorded

Executive Summary

Urgent and Emergency Care
July and August have seen periods of operational pressures, most recently through the week following the bank holiday. EU attendances and admissions reduced as expected in August but increased compared to August '25. The number of 45-minute ambulance holds increased but remained below our de-escalation standard. The % of patients waiting 12h in EU increased from 9.2% in June to 9.5% in August, above our de-escalation standard of 7%. A reset has been planned for w/c 14/9 with a suite of actions across clinical boards and operational teams to improve flow across the system, reducing long waits for patients to be seen, admitted and discharged.

Stroke and Hip Fractures
The SSNAP data tool is now operational and historic data has been updated. The time lag for regional and OOH thrombolysis patients means the C&V thrombolysis rate may change when the data is next refreshed. Door to ward compliance has been challenged through June and July but improved in August. In July 28.2% of hip fracture patients were admitted within 4h, above the UK average of 10.1%.

Delayed Pathways of Care
August saw an expected rise in DOPC to 177, in line with previous years. This remains above our de-escalation criteria of 128. The average days delayed reduced from 48 in July, to 42 in August and the total bed days lost reduced by c2500 from August '25.

Coding
We have seen an increase in % of coded episodes within 1 one month. In the most recent national data we reported 84.5% compliance in May, improved from April and significantly improved from the 36.2% reported in May'25.

Cancer
Compliance with the SCP remained steady in Q1; 60.9% of patients received their treatment within 62d in May and 63.5% in June, meeting our de-escalation standard. We have seen the total waiting list increase by 20% in the first 6m of 2026, when compared to the first 6m of 2025. This trend has seen the SCP waiting list grow by c33% since 2024. Increased demand has been a key driver of this, with the volume of patients accepted onto the SCP increasing by c70% over the past 5y. We have worked with NHSP&I to develop a trajectory to reach the 75% SCP standard by March '27. We are taking actions in key tumour sites, including additional Consultants in UGI and Urology, and specialty doctor/fellow recruitment in Skin. In the short term we continue to see growth in the total waiting list and patients waiting >62d and expect performance to drop in August.

Planned Care and Diagnostics
Waits for NOP remains reduced. Our focus this year is on productivity, including increased use of SOS/PIFU, review of clinics with high DNAs, validation of uncashed clinics and focus on activity. Our first Productivity and Efficiency Board was held in July for Executive oversight, supported by a new PowerBI resource, these continue monthly. We have seen increases in 2y waits, in-line with our forecast; driven by Dermatology, General Surgery and Orthopaedics. We have developed plans, internally and with regional partners to eliminate 2y waits regionally in as many specialties as possible. Funding allocations should be confirmed in September. The number of 3y waits remains zero
Diagnostic 8w waits increased in July. Driven by increases in Endoscopy, Echo and Radiology. This represents 50% of patients waiting less than 8w, below our de-escalation standard of 80%. A separate paper on diagnostic plans will be presented at Committee this month. August's validated position can be updated at committee.

Mental Health Measures
Our compliance against the Mental Health Measures – Part 1a (assessment) and 1b (therapeutic intervention) remains strong. Part 2 (care and treatment plan) compliance remains over 95% for CYP. Adult services saw rapid progress against the action plan, but this has plateaued at c70%. Work is ongoing to redistribute the CTPs within teams to boost compliance, with increases noted in June and July.

Executive Actions and Owners

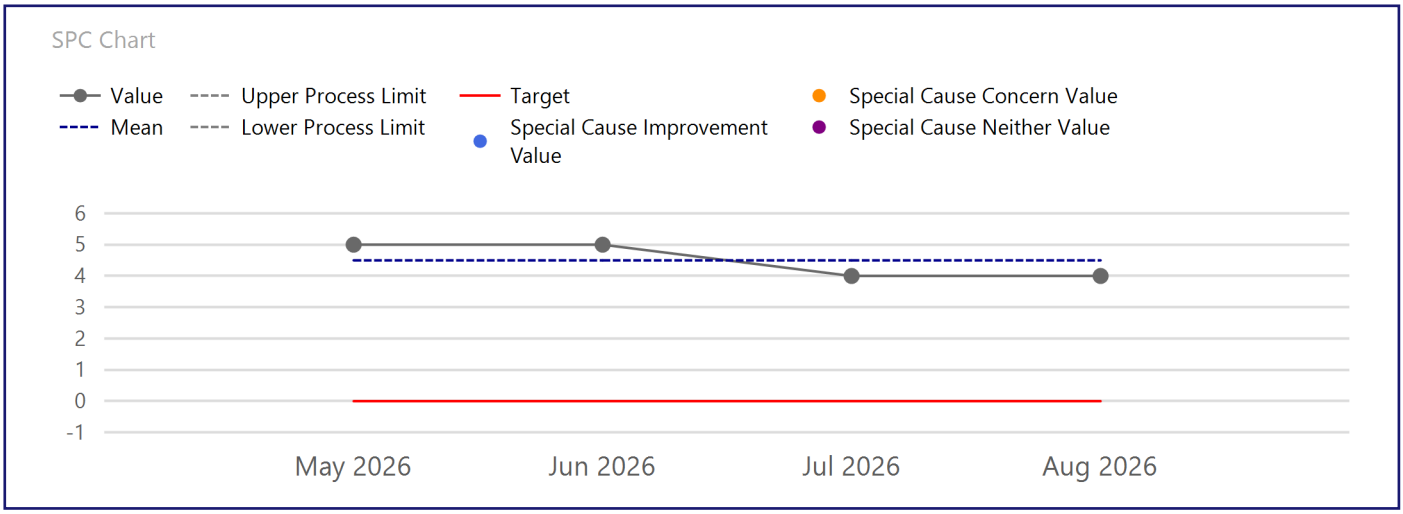
Operational system 'Reset' - W/C 14/9/26 (Mike Bond)

Previous Months Executive Actions and Owners

No previous month actions recorded

Metric ID: 10000060 Nationally reportable incidents open over 12 months

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	4	0			Executive Director of Nursing



Narrative

There were four nationally reportable incidents open at the end of June 2026. All four incident reviews have extended beyond their planned review time.

Actions and Owners

Plans have been made between the Patient Safety Team and the Clinical Boards to manage these reviews. Three of the five outstanding incidents reported last month were closed as planned. Two further incidents have met the criteria for over 12 months in August.

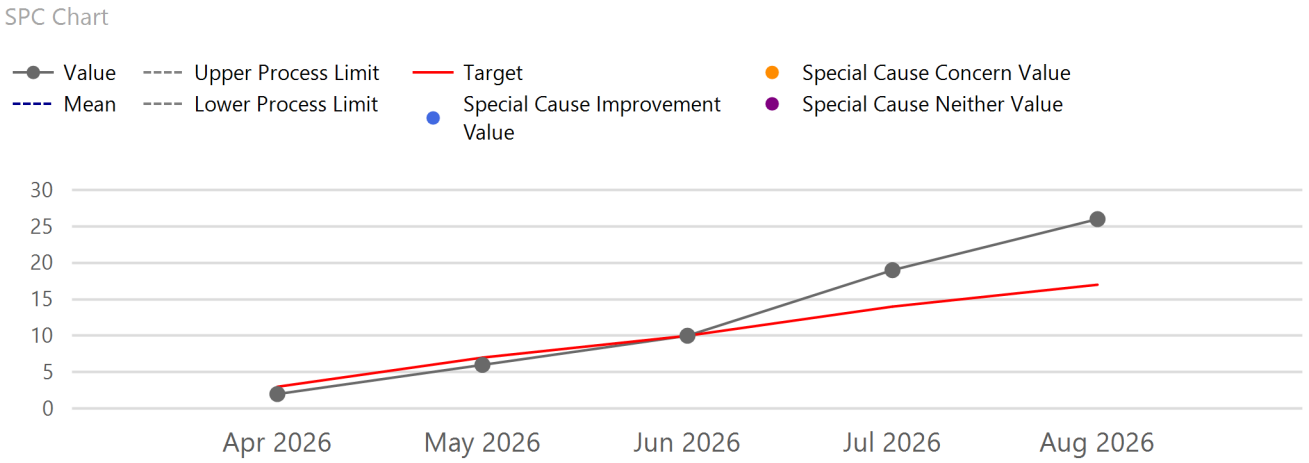
Each Clinical Board has been set an improvement trajectory to achieve zero nationally reportable incidents extending beyond their planned closure time, however five of seven clinical boards did not achieve their improvement target in August 2026. Their performance against these trajectories is overseen in the Executive Performance Reviews. The clinical boards have made very significant improvements in the management of patient safety incidents demonstrating a 205 reduction in open incidents in the past 10 months .

Concerns

Constraints in clinical board capacity to progress nationally reportable incident reviews is leading to delays beyond the agreed timescales. One outstanding incident has been jointly reported and reviewed with a second Health Board in Wales. Progressing this review is not within the control of the UHB

Metric ID: 10000061 Cumulative number of hospital onset Klebsiella spp BSI cases

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	26	17	F		Executive Director of Nursing



Narrative

Welsh Government have set a target that the UHB reduce their hospital onset Klebsiella species bacteraemia by 10% from the 2024/25 rate between April 2025 and March 2027. The UHB set itself an internal target of no more than 45 hospital onset cases by the half way point (March 2026) and the Health Board did not achieve this reduction reporting 56 cases.

Actions and Owners

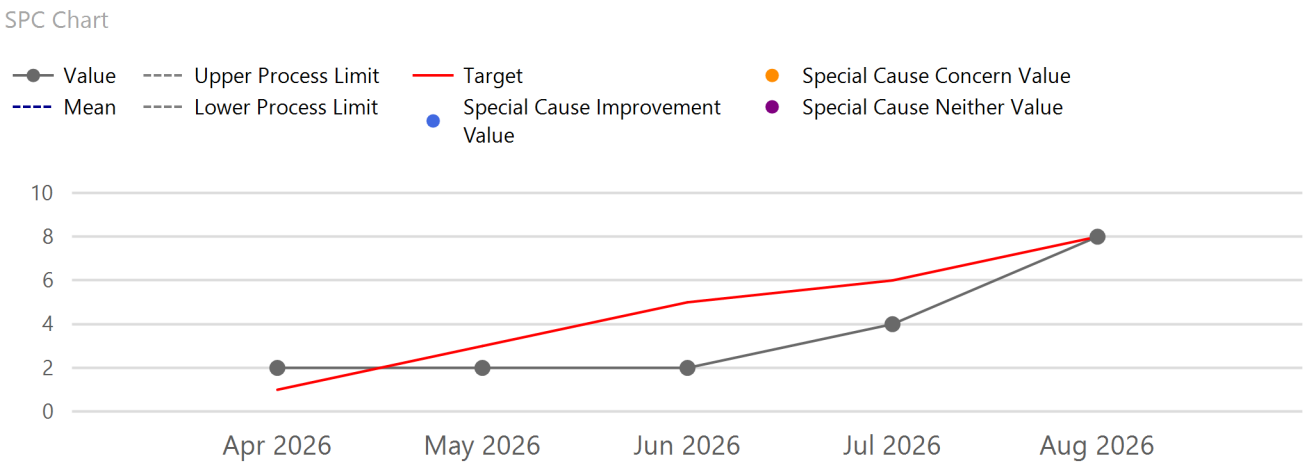
The IP&C team continue to monitor the number of cases and review the RCA's to identify themes which will be used to inform education and training for clinical teams

Concerns

the increase in numbers is a concerns, all Klebsiella sp's cases have a root cause analysis (RCA) undertaken however these are not identifying deficiencies in care and all cases have been deemed as unavoidable.

Metric ID: 10000062 Cumulative number of hospital onset Pseudomonas aeruginosa BSI cases

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	8	8	P		Executive Director of Nursing



Narrative

Welsh Government have set a target that the UHB reduce their hospital onset Pseudomonas aeruginosa bacteraemia by 25% from the 2024/25 rate between April2025 and March 2027. The UHB set itself an internal target of no more than 26 hospital onset cases by the half way point (March 2026) and the Health Board exceeded this reduction reporting 13 cases.

Actions and Owners

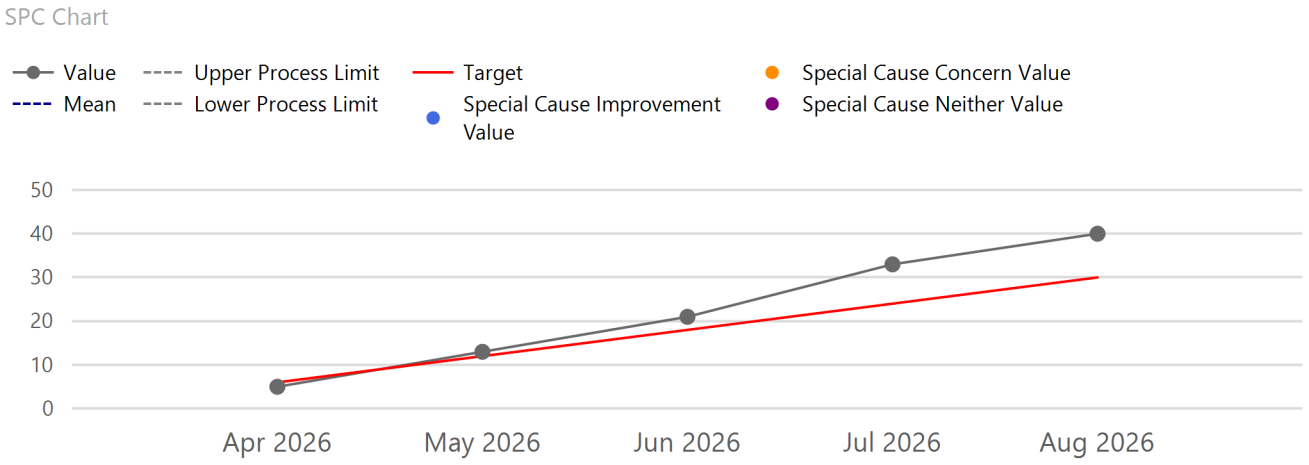
The IP&C team will continue to monitor the number of cases and review the RCA's to identify themes which will be used to inform education and training for clinical teams

Concerns

All PAER cases have a root cause analysis (RCA) undertaken however these are not identifying deficiencies in care and all cases have been deemed as unavoidable

Metric ID: 10000063 Cumulative number of hospital onset E.coli BSI cases

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	40	30	F		Executive Director of Nursing



Narrative

Welsh Government have set a target that the UHB reduce the number by hospital onset cases of E. coli bacteraemia by 10% from the 2024/25 rate between April 2025 and March 2027. The UHB set itself an internal target of no more than 79 hospital onset cases by the half way point (March 2026) and the Health Board exceeded this reduction reporting 64 cases.

Actions and Owners

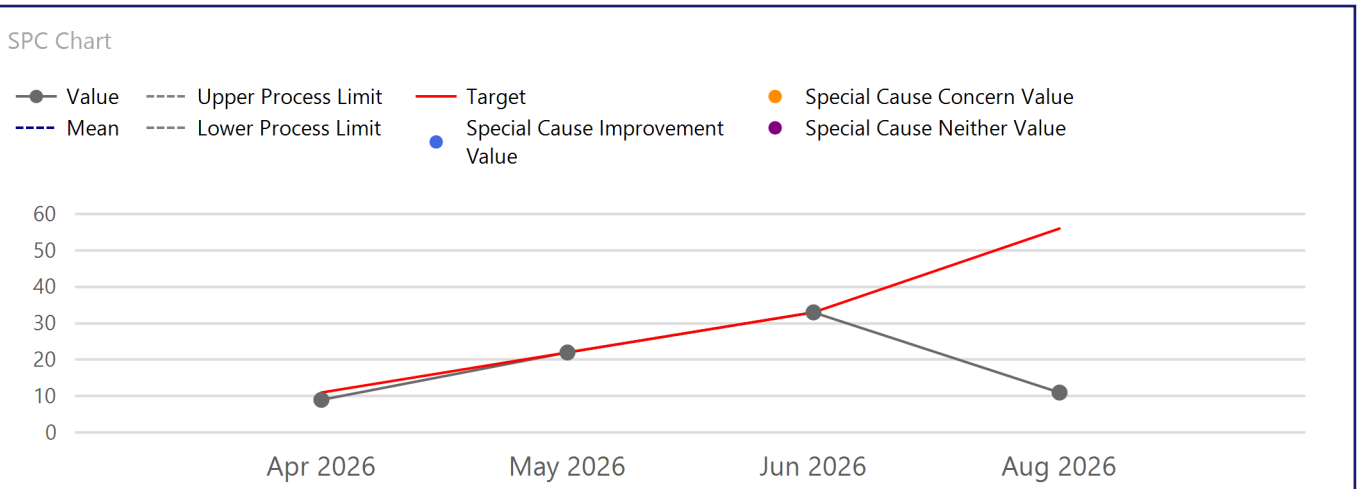
The Infection Prevention and Control team are increasing their programme of urinary catheter insertion and maintenance audits that they undertake and using this data to reinforce the required standards in individual clinical areas

Concerns

Compliance with urinary catheter insertion and care bundles ranges between 50 and100%, further education and training is required which will be addressed by the continence and IP&C teams

Metric ID: 10000064 Cumulative number of MSSA BSI cases

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	11	56	P		Executive Director of Nursing



Narrative

Welsh Government have set a target that the UHB reduce its number of MSSA by 20%from the 2024/25 rate between April 2025 and March 2027. The UHB set itself an internal target of no more than 152 cases by the half way point (March 2026) and exceeded this reduction reporting 131 cases. If we continue the current trajectory the UHB will achieve the reduction goal.

Actions and Owners

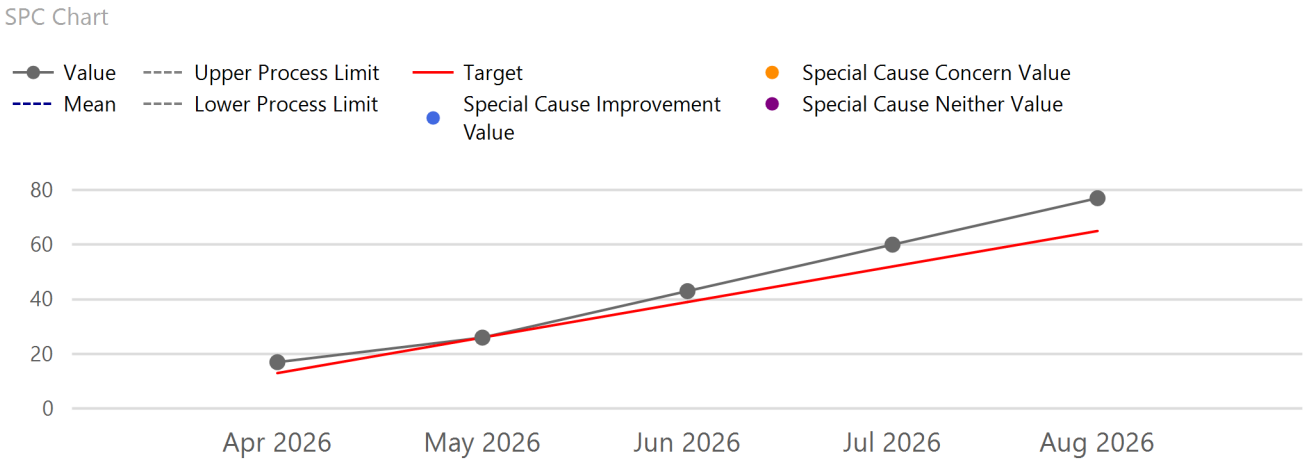
The Infection Prevention and Control team are increasing their programme of peripheral vascular catheter and central venous catheter insertion and maintenance bundle compliance audits that they undertake and using this data to reinforce the required standards in individual clinical areas.

Concerns

Anecdotally medical Compliance with Aseptic Non -Touch Technique (ANTT) is poor, training cannot be monitored with any confidence due to issues around recording of training attendance and competency assessment on ESR. Work being undertaken nationally to review ESR will address this issue.

Metric ID: 10000065 Cumulative number of C.difficile infection cases

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	77	65	F		Executive Director of Nursing



Narrative

There has been an increase in C. diff cases nationally over the past five years. WG issued a reduction expectation of 25% of cases reported in 24/25 to be achieved by March 2027. The UHB set itself an internal target of 184 by the half way point (March2026) but exceeded this number (186). The greatest number of cases observed were in paediatric oncology. In response with the C. diff Collaborative, targeted work has led to a 75% reduction in cases in this speciality. This work has included education for paediatric workforce to improve sampling techniques, isolation processes, antimicrobial review at 48 and 72 hours and decontamination of the room and equipment on discharge or resolution of infection.

Actions and Owners

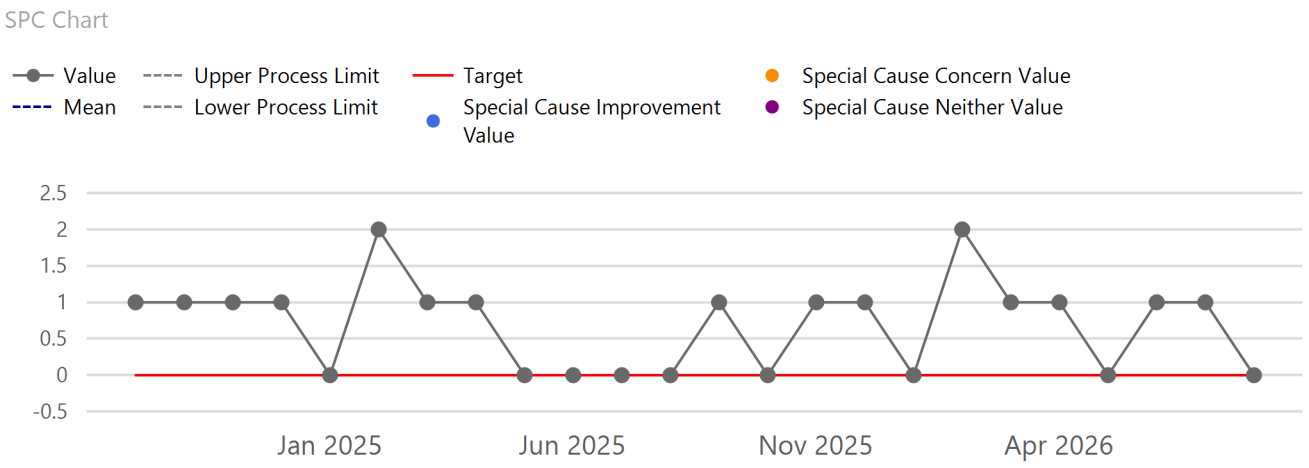
An education tool has been developed to provide an accessible resource for staff that aligns to the information that was provided to the paediatric workforce and was effective in delivering the improvement. There are ongoing constraints around making the education resource easily accessible for all staff by hosting on desktops on computers in clinical settings however the tool has been shared with all Clinical Board Directors of Nursing for cascade to clinical teams and is available on Sharepoint for all staff to access.
An improvement plan for the organisation has been developed and all Clinical Boards are developing their improvement plans to deliver against the organisational plan.

Concerns

There continues to be a rise in C.Diff cases, despite ongoing focus on improvements.

Metric ID: 10000066 Number of Never Events

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	0	0	P		Executive Director of Nursing



Narrative

The Health Board have reported eight Never Events in the past twelve months, Never Events are by definition incidents that are deemed to be avoidable due to the checks and balances that in place to prevent these from happening.

These incidents relate to medication administration via the incorrect route, retained foreign objects post procedure and insulin administration using the incorrect device.

Actions and Owners

The UHB has implemented a UHB National Safety Standards for Invasive Procedures group which will oversee the development and governance of all invasive procedures across the UHB ensuring standardisation and governance.

Communication from the Executive Nurse Director and Executive Medical Director was sent out across the entire UHB to remind staff of the requirement to use specific insulin devices when preparing insulin for administration. Insulin specific devices have been introduced into the perioperative directorate for preparing of insulin infusions, this has brought the Directorate in line with practice across the rest of the Health Board.

An August 2026 WHO Surgical Safety Checklist audit across four theatre suites reviewed 11 patient episodes and found consistently high compliance, with Team Brief, Sign In, Time Out, “happy to proceed” check and Sign Out completed and documented in all audited cases, providing positive assurance that the checklist process is well embed

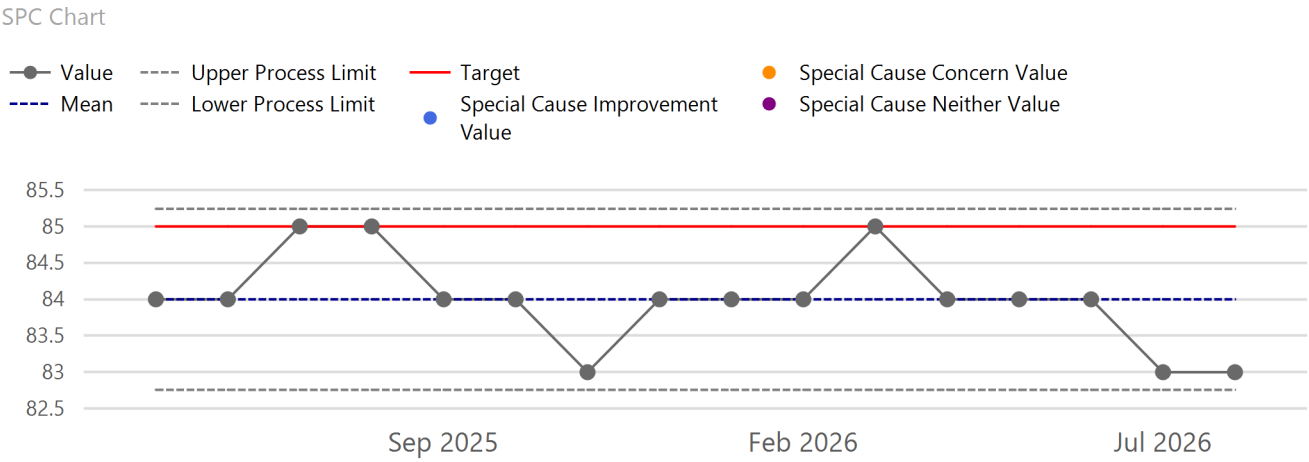
Concerns

These incidents relate to medication administration via the incorrect route, retained foreign objects post procedure and insulin administration using the incorrect device.

Each of these incidents demonstrates deviation or weaknesses in established checking processes. Specifically, the use of EN fit syringes to draw up and administer medications via an enteral route. The use of non insulin specific devices for insulin preparation in the perioperative environment and weaknesses in the intra operative surgical count process.

Metric ID: 10000067 Overall HB overall patient experience score

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	83	85			Executive Director of Nursing



Narrative

Overall patient experience scores remained stable at 83% in both July and August, indicating a consistently positive experience across Health Board service

Actions and Owners

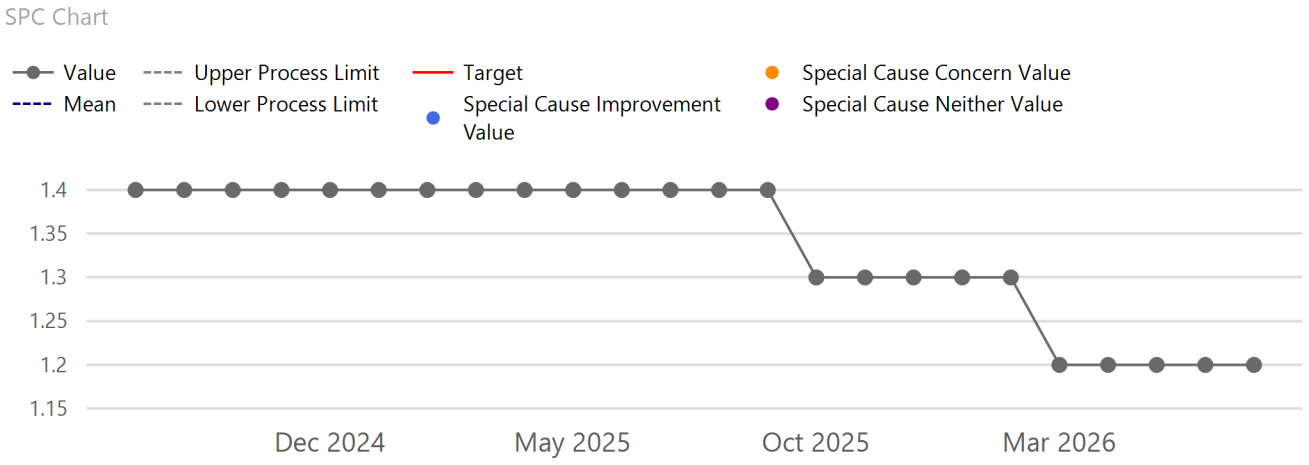
Learning from patient experience feedback continues to be reviewed through governance arrangements and used to inform quality improvement initiatives, with a particular focus on strengthening communication, patient engagement and coordination of care.

Concerns

The main themes identified for improvement relate to communication, including the provision of timely updates, clarity of information, and continuity of communication throughout the patient journey. Feedback also highlighted concerns regarding waiting times and service coordination, particularly where patients required input from multiple teams.

Metric ID: 10000068 Crude rolling 12 month Inpatient Mortality

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	1.2				Executive Director of Nursing



Narrative

Crude mortality demonstrates the annualised proportion of inpatients that die in hospital.

The UHB has sustained a eight month reduction in crude mortality below the mean, since November 2025 with an annualised rate of 1.2% in April and May 2026. The UHB has remained below the All-Wales rate since April 2024 and has reported the lowest crude annual mortality rate in Wales of all Welsh health organisations during this period.

Actions and Owners

UHB Mortality governance is being strengthened by introducing a standardised Mortality and Morbidity tool. The M&M tool will be hosted on the UHB digital clinical governance systems (AMaT), providing oversight of Medical Examiner referrals, and . Individualised support is being provided to directorates to implement, led by the Patient Safety team. Over the next three months Major Trauma, Gynaecology and Haematology directorate swill be supported to implement an effective M&M process and to utilise the AMaT tool.

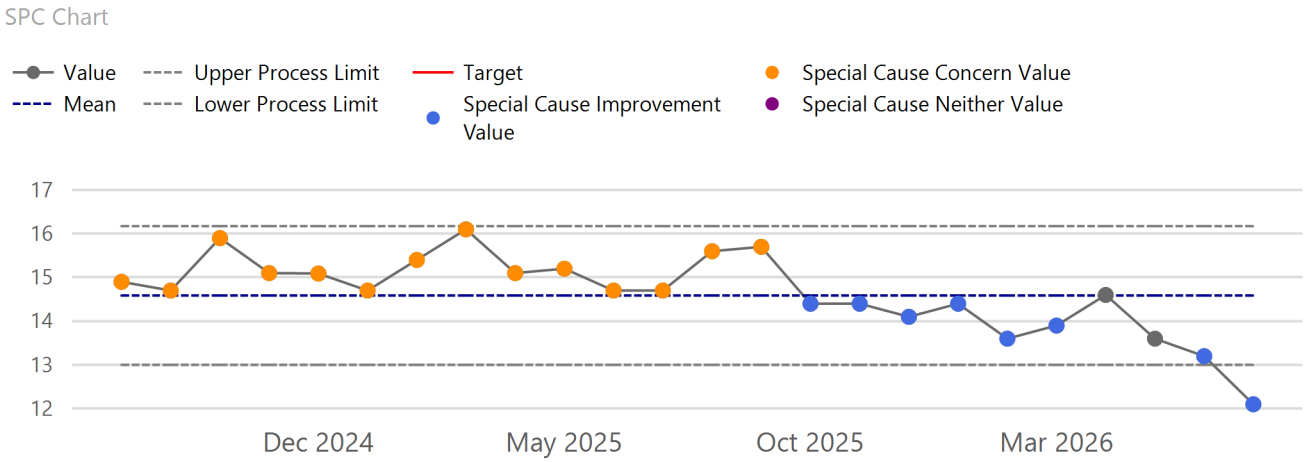
Concerns

This measure does not adjust for risk and therefore will not take into account complexity or risk of each individual or calculate their risk of dying.

There is variation in Mortality and Morbidity review processes across the UHB resulting in limitations around the ability to scrutinise outcomes in the event of increasing mortality rates.

Metric ID: 10000069 Stroke Mortality within 30 days following admission with stroke (CHKS)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	12.1				Executive Director of Nursing



Narrative

Stroke Mortality is measured as part of the Sentinel Stroke National Audit Plan (SSNAP) and as a risk adjusted rolling annual mortality.

SSNAP mortality between August 2024 and August 2025 was 9.4% in line with the national SSNAP mortality rate. Adjusted annual rolling mortality for the same period was between 14.7% and 16.1% and significantly above the All-Wales rate.

For the previous nine months adjusted rolling annual mortality has shown a sustained improvement falling below the mean with a rate of 12.1% in July 2026. However, this remains above the All- Wales average which was 11.4% in July 2026.

Actions and Owners

Local work undertaken between the stroke services and clinical coding team is ongoing and is focused on improving the accuracy and timeliness of stroke coding.

UHB wide work to deliver improved compliance with clinical coding is underway. A decision was made to shift coding resources from meeting outstanding 2025 /2026 coding requirements to prospective coding for 2026/27. Coding of episodes of care within 1 month of discharge is 77.37% since April

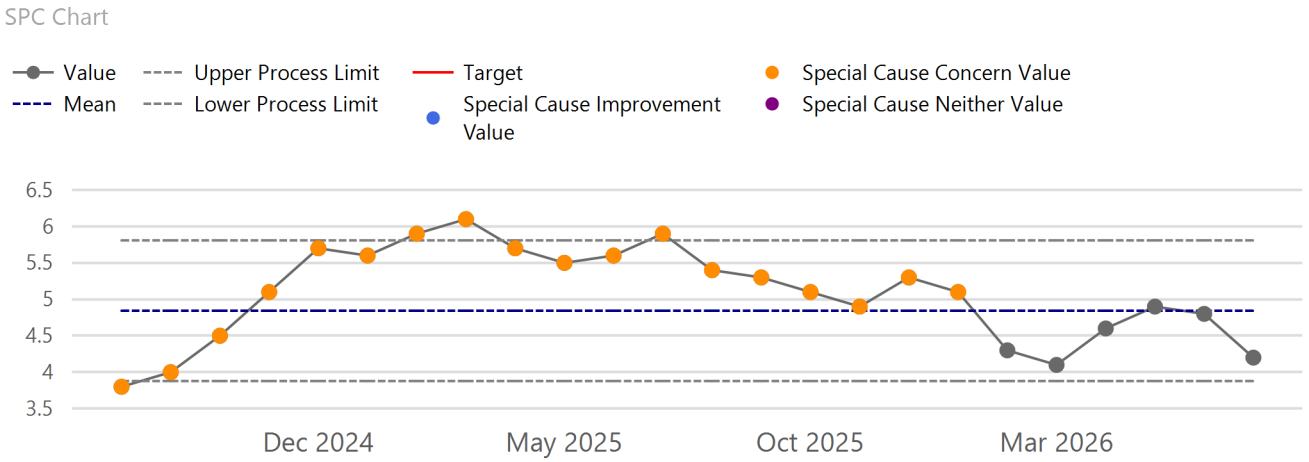
Concerns

Scrutiny of clinical coding of stroke cases has demonstrated inaccuracies and delays in the coding of cases which is resulting in inaccurate and elevated annual rolling mortality rates.

Variation in the reliability of data impacts on the ability of the organisation to have a responsive approach to mortality governance and its ability to put in place appropriate actions and scrutiny of deaths

Metric ID: 10000071 Hip Fracture Mortality within 30 days following admission with hip fracture

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	4.2				Executive Director of Nursing



Narrative

Hip Fracture mortality is recorded through the National Hip Fracture Database as well as a rolling annual case adjusted mortality indicator.

Cardiff and Vale Mortality as recorded in the National Hip Fracture Database was well above the national average throughout 2025 and was at or close to the upper control limit (two standard deviations) between 6.6% -7% throughout 2025 and the first quarter of 2026.

The All-Wales rolling mortality rate in July 2026 was 4.8% and the UHB recorded a rate of 4.2% and rolling annual mortality throughout 2025 was between 4.7% and 6.1

Actions and Owners

Improvements in clinical coding will support greater reliability of risk adjusted hip fracture mortality data and will therefore support a more informed approach to responding to changes in mortality rates.

The implementation of the standardised Mortality and Morbidity module will provide greater scrutiny and oversight of hip fracture mortality.

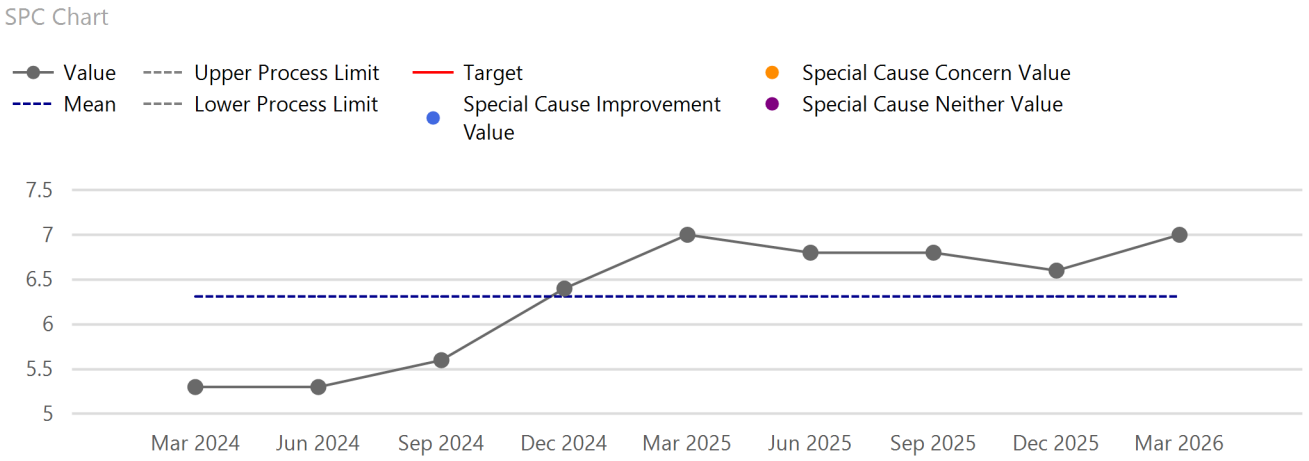
Concerns

Variation in mortality data between the National Hip Fracture Data base and adjusted rolling mortality hip fracture mortality means that a responsive approach to scrutinising variation in mortality rates

Metric ID: 10000072

Hip Fracture Mortality within 30 days following admission with hip fracture (NHFD)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
March 2026	7				Executive Director of Nursing



Narrative

Cardiff and Vale Mortality as recorded in the National Hip Fracture Database was well above the national average throughout 2025 and was at or close to the upper control limit (two standard deviations) between 6.6% -7% throughout 2025 and the first quarter of 2026.

The All-Wales rolling mortality rate in July 2026 was 4.2% and the UHB recorded a rate of 4.8% and rolling annual mortality throughout 2025 was between 4.7% and 6.1%.

Actions and Owners

Improvements in clinical coding will support greater reliability of risk adjusted hip fracture mortality data and will therefore support a more informed approach to responding to changes in mortality rates.

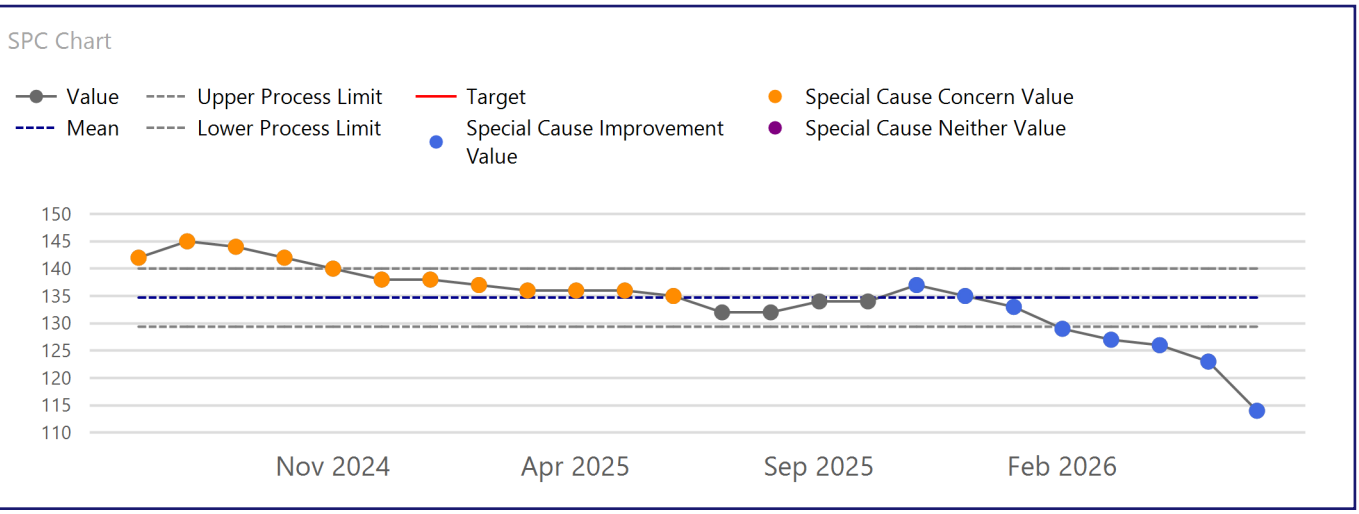
The implementation of the standardised Mortality and Morbidity module will provide greater scrutiny and oversight of hip fracture mortality.

Concerns

Variation in mortality data between the National Hip Fracture Data base and adjusted rolling mortality hip fracture mortality means that a responsive approach to scrutinising variation in mortality rates

Metric ID: 10000073 Risk Adjusted Mortality Index

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	114				Executive Director of Nursing



Narrative

Annualised Risk Adjusted Mortality Index is a measure that risk adjusts for variables such as underlying health of patients, co-morbidities and procedures being undertaken. The average RAMI is described as 100 and it is anticipated that 50% of patient will fall above this average and 50% below. RAMI is rebased annually to take into account annual variation in the "norm."

There has been a significant reduction in UHB RAMI and for the past four months has been below the lower control limits. Despite this improvement RAMI remains well above 100 (112 in August) and the UHB is recording the second highest RAMI amongst Welsh health organisations.

Actions and Owners

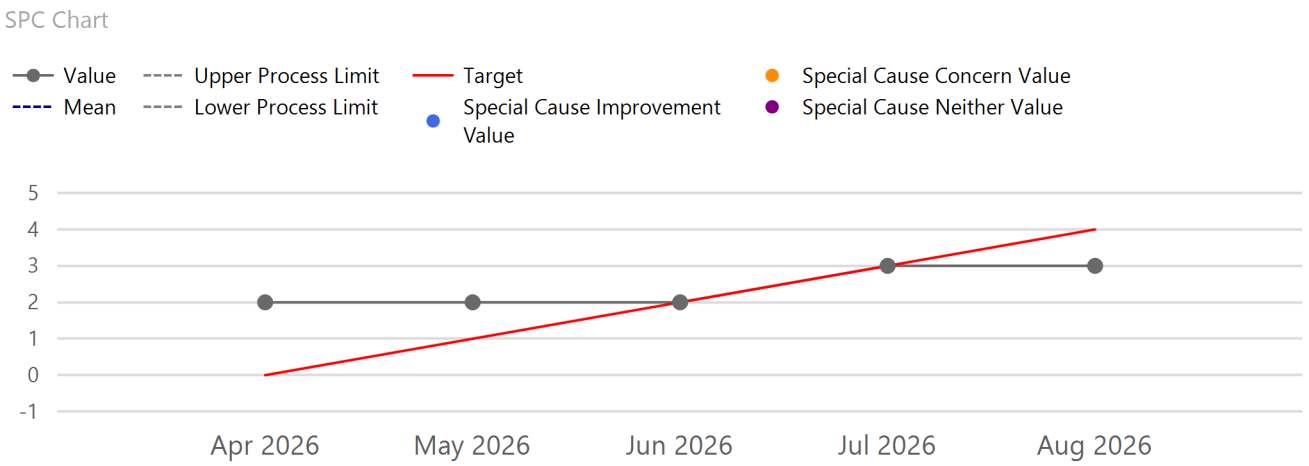
A decision was made to shift coding resources from meeting outstanding 2025 /2026 coding requirements to prospective coding for 2026/27. Coding compliance was 62.39% nearing the end of August 2025, a reduction on previous months, however overall completion rates since April 2026 were 77.37 compared to 72.12 at the same point in 2025

Concerns

Delays in clinical coding and prioritisation of coding of deceased patients episodes of care has resulted in elevated RAMI and therefore impacts on the reliability of the data and the ability of the UHB to use RAMI as a quality indicator. Coding compliance was 62.39% nearing the end of August 2025, a reduction on previous months

Metric ID: 10000167 Cumulative number of hospital onset MRSA BSI cases

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	3	4	P		Executive Director of Nursing



Narrative

Welsh Government have set a target that the UHB reduce their MRSA rates reported in 2024/2025 between April 2025 and April 2027. However, the 2025/26 reporting rate exceeded that of the previous year with 18 cases reported in total of which 8 were hospital onset and approximately half of these were related to line insertion.

Actions and Owners

The IP&C team will be increasing their peripheral vascular catheter and central venous catheter insertion and maintenance bundle compliance audits to assess adherence with the insertion and care bundles. Executive reviews are now focusing on MRSA cases with scrutiny of route cause analysis of each case chaired by the Executive Medical Director and Executive Nurse Director and supported by the IP&C and clinical teams. There is an overarching organisational improvement plan and each Clinical Board are also providing their improvement plans

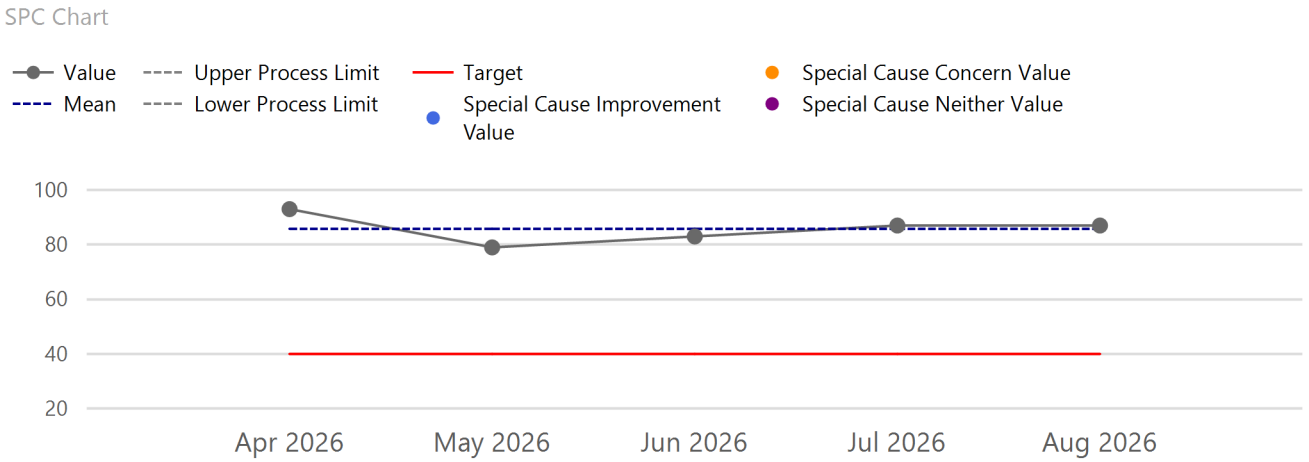
Concerns

The UHB is reporting the third highest rate of MRSA in Wales. ANTT training uptake amongst medical workforce is low, however training compliance data on ESR is unreliable. A national update of ESR should result in usable training data. MRSA admission screening compliance is not where we would want it however compliance is improving

Metric ID: 10000168

Percentage of suitable complaints dealt with through the early resolution process

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	87	40			Executive Director of Nursing



Narrative

87% of complaints were resolved through Early Resolution, significantly exceeding the 40% target%. T

Actions and Owners

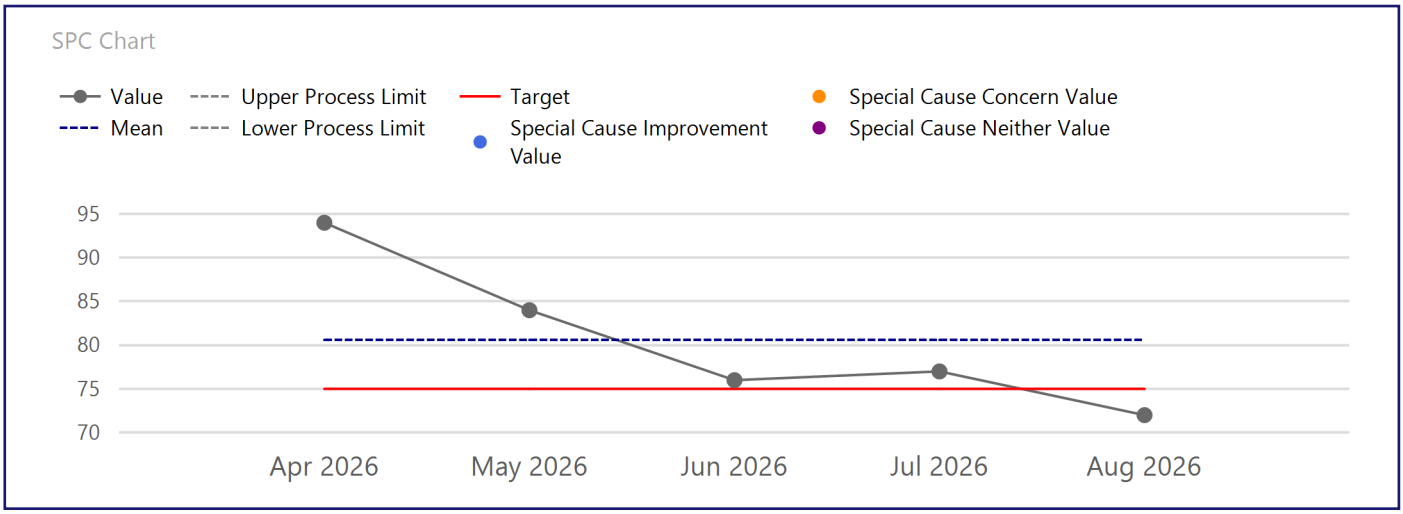
his demonstrates effective local management of concerns, enabling issues to be addressed promptly and reducing the need for formal investigation where appropriate.

Concerns

Early Resolution continues to provide timely responses for patients and families whilst supporting organisational learning and service improvement

Metric ID: 10000169 Compliance with selected response timeframe for all complaints investigations

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	72	75			Executive Director of Nursing



Narrative

July performance: 77%
August performance: 72%
5 percentage point reduction month-on-month.
Focus remains on improving timeliness whilst maintaining the quality, compassion and learning requirements of the Listening to People framework.

Actions and Owners

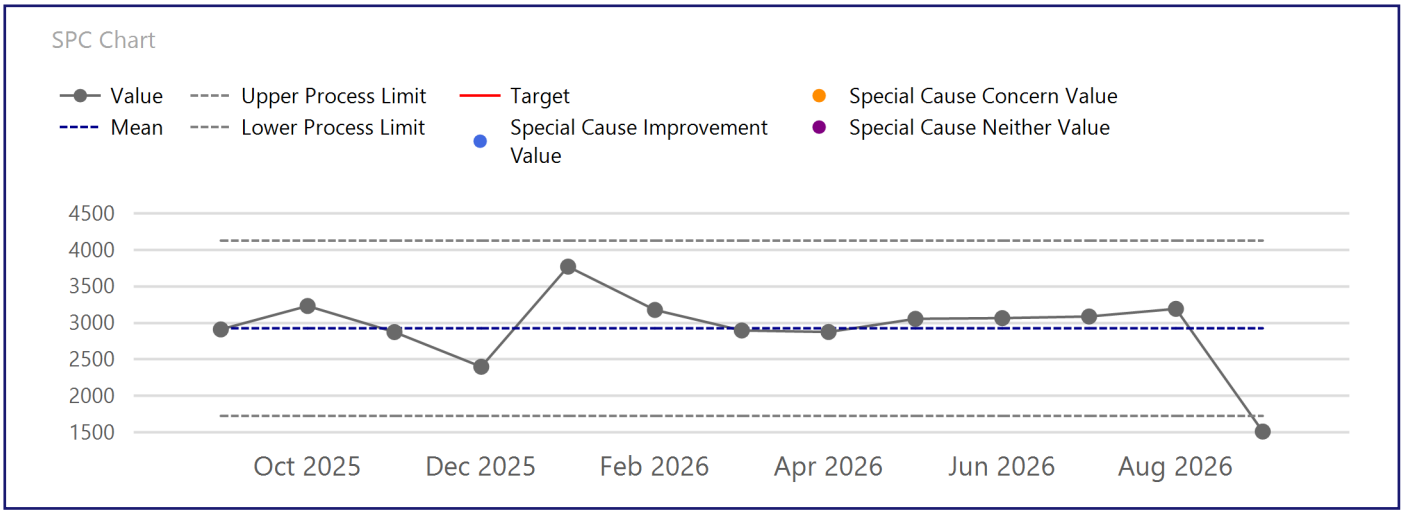
Actions to Improve Performance
Weekly concerns tracker meetings established with Clinical Boards to review overdue cases, agree recovery actions and monitor progress.
Strengthened accountability arrangements through regular escalation of delayed responses.
Development of a complaints management system to improve case tracking and oversight.
Introduction of a performance dashboard to provide real-time monitoring of compliance with LTP timescales.
Enhanced thematic reporting to identify trends, support organisational learning and inform quality improvement initiatives.
Continued focus on embedding the Listening to People principles of timely communication, transparency and compassionate engagement.

Concerns

Volume and complexity is challenging

Metric ID: 10000170 Service Desk - Incidents Raised in the Month

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	1513				Director of Digitial and Health Informatics



Narrative

Number of Incident Raised by Month

Actions and Owners

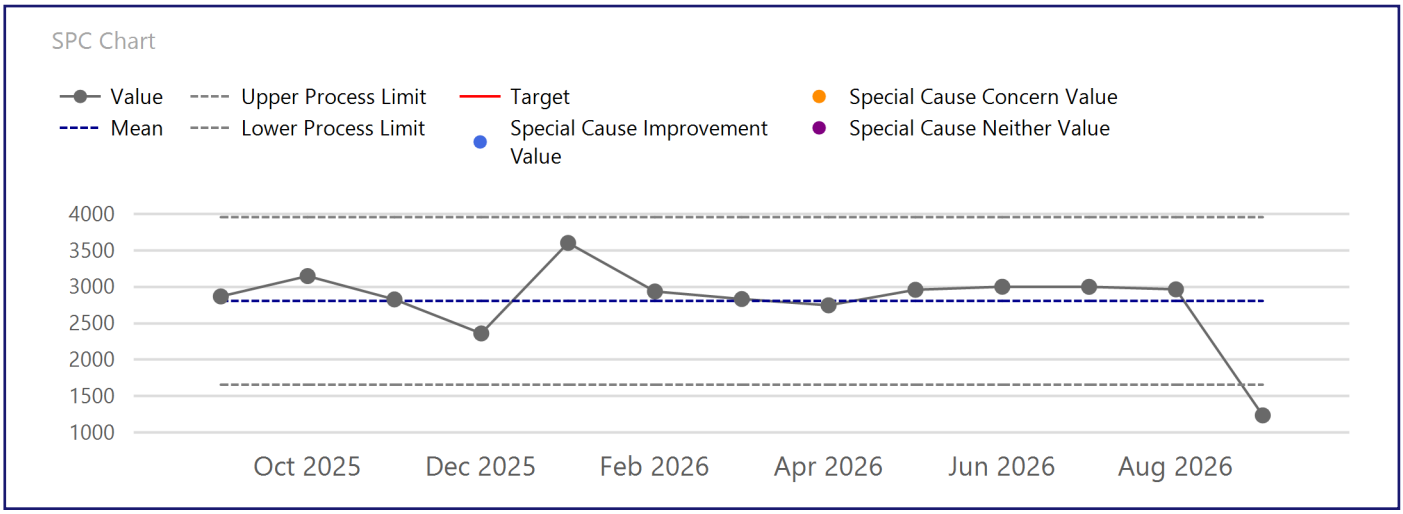
Number of Incident Raised by Month

Concerns

Number of Incident Raised by Month

Metric ID: 10000171 Service Desk - Incidents Closed in the Month

Latest Month	Value	Target	Assurance	Variation	Metric Owner
September 2026	1237				Director of Digitial and Health Informatics



Narrative

Number of Incident Closed by Month

Actions and Owners

Number of Incident Closed by Month

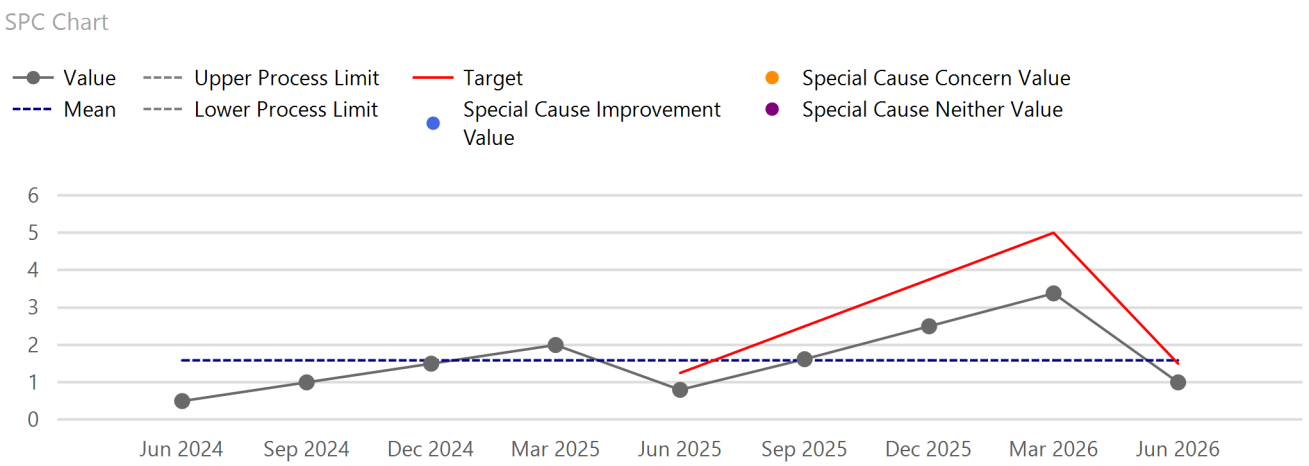
Concerns

Number of Incident Closed by Month

Metric ID: 10000001

Percentage of adult smokers who make a quit attempt via smoking cessation services

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	1	1.5			Executive Director of Public Health



Narrative

Annual target is 7.5% of the estimated 38,800 Cardiff and Vale residents who smoke (n=2,910). Q1 target is 1.5% of the estimated 38,800 Cardiff and Vale residents who smoke (n=582); Q2 target is 3.5% (n=1,358, cumulative); Q3 target is 5.5% (n=2,134, cumulative); Q4 target is 7.5% (n=2,910).

This quarter, a total of 381 adult smokers made a quit attempt via smoking cessation services. This means that services supported 1.0% of the Cardiff and Vale adult smoking population. This compares with the Q1 target of 1.5% and the annual target of 7.5%.

Performance in Q1 2026/27 continues to improve on performance in 2025/26 but falls short of the target. Performance continued to improve in Help Me Quit Community and Allen Carr Easyway services, remained steady in Help Me Quit telephone hub and Hospital services, but fell significantly in the community pharmacy service.

Actions and Owners

Reasons for significant drop in activity in community pharmacy to be explored and mitigated where possible.

Concerns

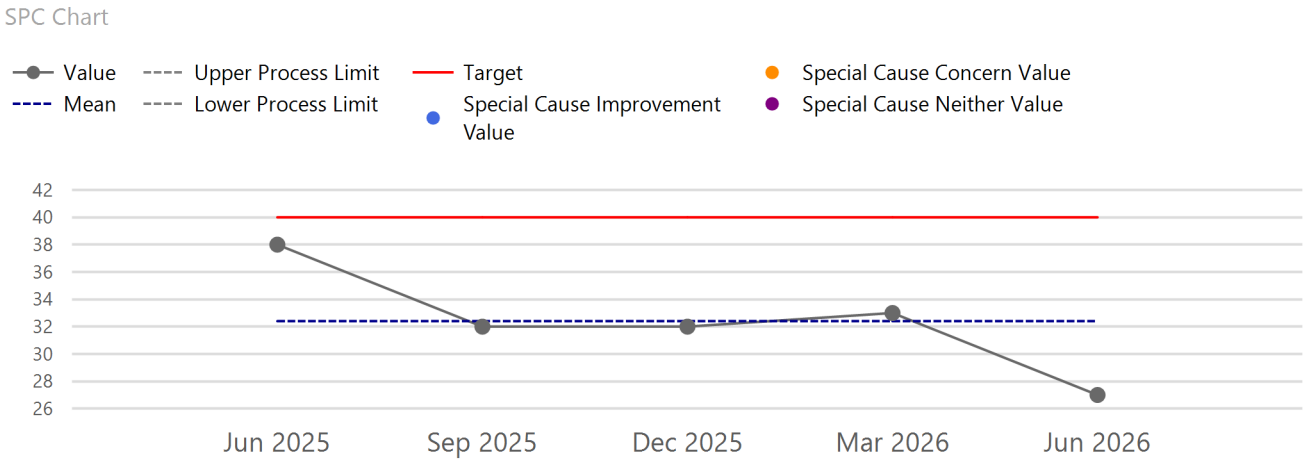
Below target.

While performance against this target continued to improve in HMQ Community and Allen Carr Easyway services, it remained steady in Help Me Quit telephone hub and Hospital services, but fell significantly in the community pharmacy service.

Metric ID: 10000002

Percentage of adult smokers who make a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	27	40			Executive Director of Public Health



Narrative

All smoking cessation services combined = 27.3%

Below target overall (but note variation by service).

Breakdown:
- 40.6% Help Me Quit (HMQ) Community (excl. PHW HMQ telephone hub) - service meets target
- 0.0% PHW HMQ telephone hub - service does not meet target
- 15.1% Allen Carr Easyway - service does not meet target
- 21.3% HMQ Community Pharmacy - service does not meet target
- 47.1% Hospital Cessation Service - service meets target

Actions and Owners

Staff deployed to raise CO validation where possible within resources available.

Concerns

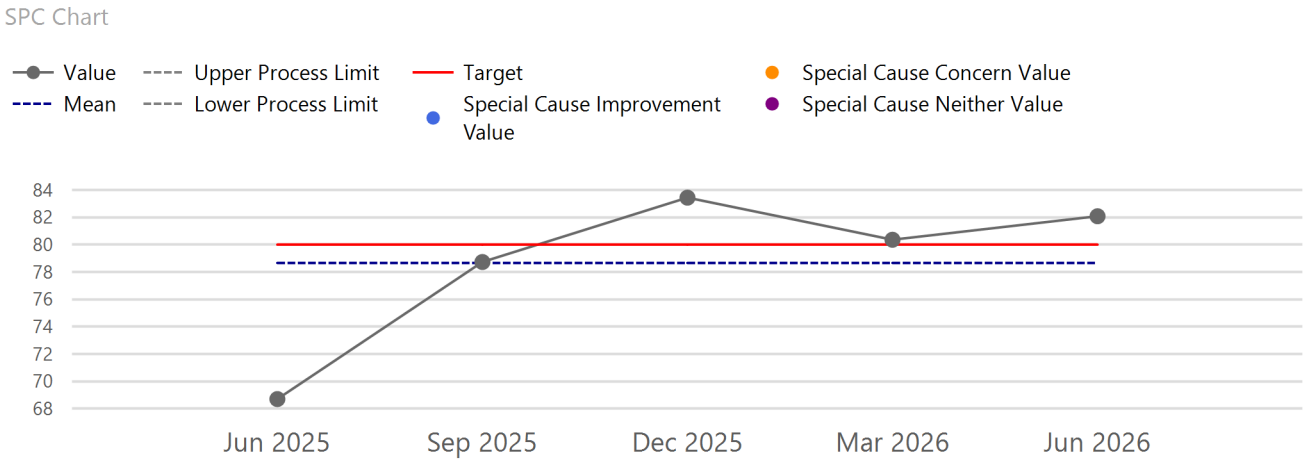
Below target.

Performance against this target was above target in HMQ Community and Hospital services, but it fell short of the target in all other smoking cessation services.

Metric ID: 10000003

Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs and alcohol)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	82.08	80			Executive Director of Public Health



Narrative

The performance indicator remains above the 80% target, with minor quarter-on-quarter variation.

Actions and Owners

Substance use key performance indicators are reviewed regularly in meetings of the Cardiff and Vale Area Planning Board (APB). The APB is made up of partner organisations that work collaboratively, through a whole system approach, towards preventing and reducing harm from substance use and developing, delivering and improving efficient and effective substance use services, to meet the need of the local population.

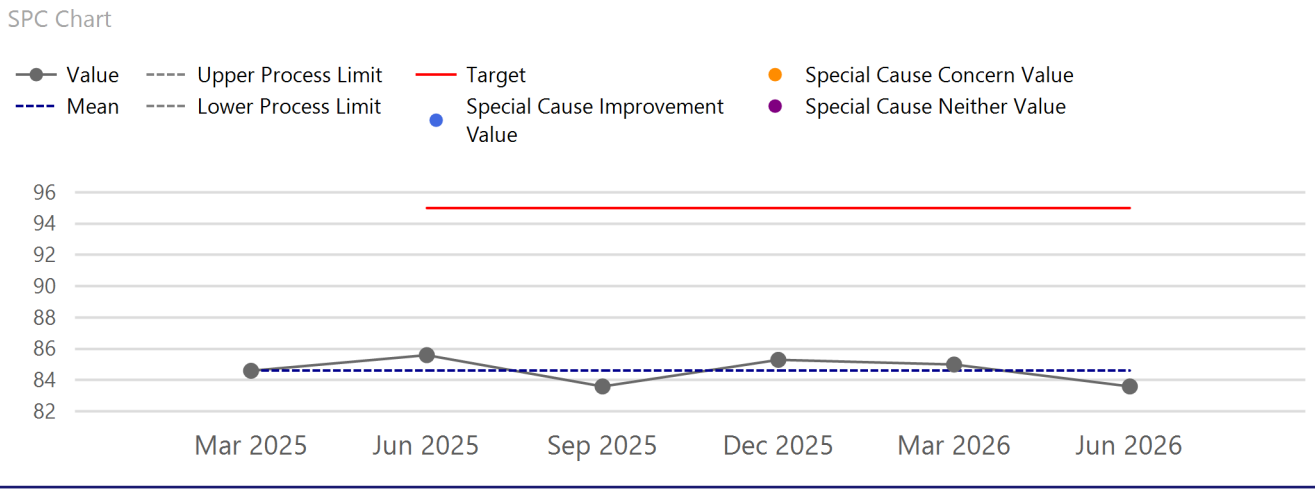
Concerns

None

Metric ID: 10000004

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)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	83.6	95			Executive Director of Public Health



Narrative

The gap has widened from 2.5% to 3.6%, but not to the extent of the gap recorded in the Q3 2024/25 of 4.8%

Actions and Owners

A delivery plan of detailed actions to improve this outcome has been developed and embedded into the 2026/27 delivery plan of the Childhood and Teenage Immunisations Strategic Action Plan (2026-2029).

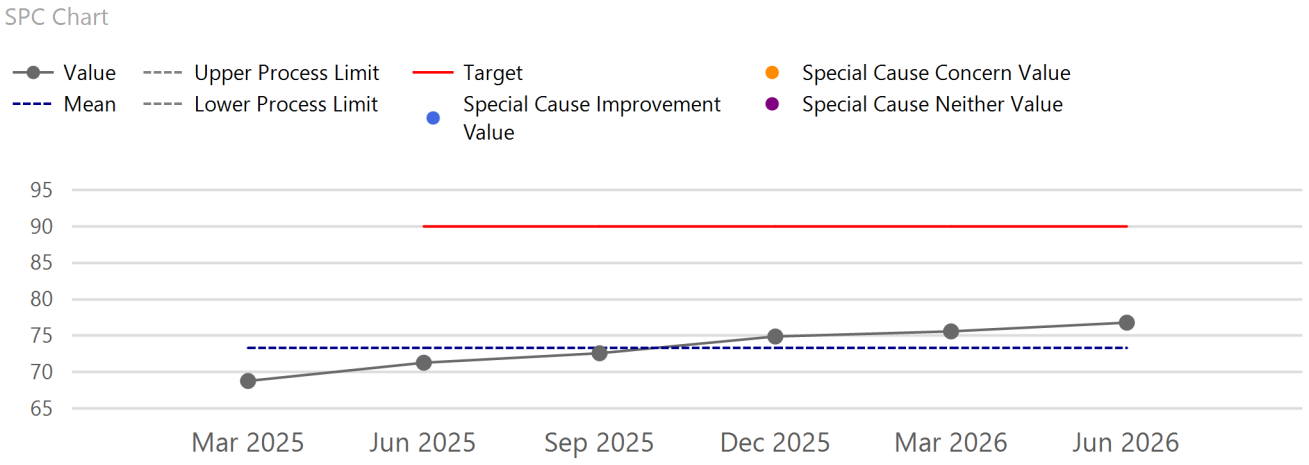
Concerns

No concerns, all actions planned for the year to improve this outcome are underway.

Metric ID: 10000005

Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	76.8	90			Executive Director of Public Health



Narrative

School Nursing Immunisation colleagues have delivered the programme this season including additional catch-up clinics which has continued to narrow the gap between CAV and the Wales average to 0.1%

Actions and Owners

A delivery plan of detailed actions to improve this outcome has been developed and embedded into the 2026/27 delivery plan of the Childhood and Teenage Immunisations Strategic Action Plan (2026-2029)

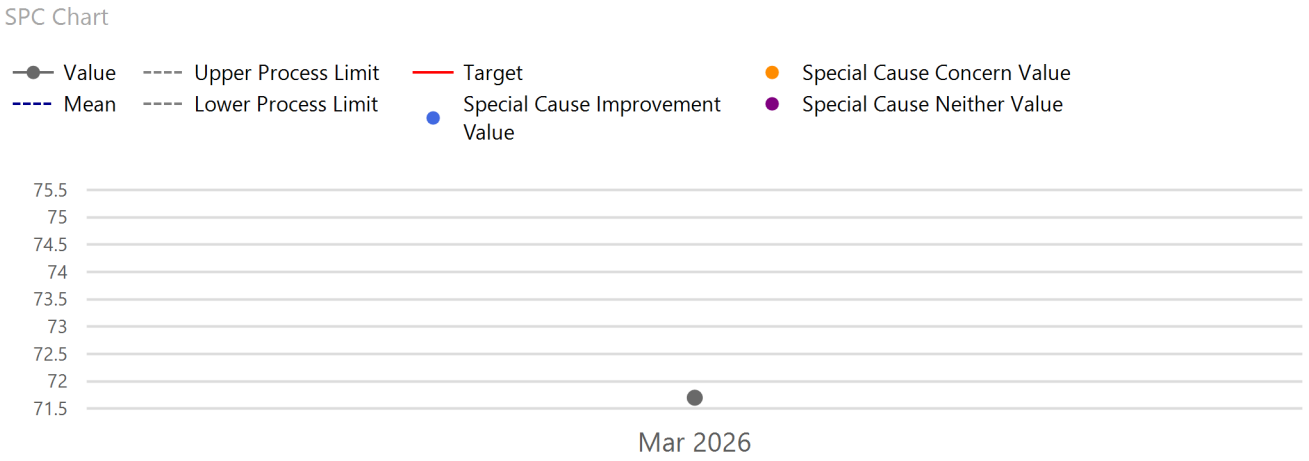
Concerns

None

Metric ID: 10000006

Percentage uptake of the influenza vaccination amongst adults aged 65 years and over

Latest Month	Value	Target	Assurance	Variation	Metric Owner
March 2026	71.7	75			Executive Director of Public Health



Narrative

The Autumn influenza campaign commenced 1 October 2025 for residents aged 65 years and over and concluded on 31 March 2026.

67,897 out of 94,751 residents in CAVUHB aged 65 and over were vaccinated. This is an uptake of 71.7%, equal to the all-Wales average.

Actions and Owners

Joint Health Board flu evaluation session held in April 2026, planning underway for the 2026/27 season. Review of capacity to deliver flu vaccination programme 2026/27 underway, particularly in light of aim to continue provision of an equitable offer for injectable gelatine-free vaccination in schools, and introduction of time-limited MenB vaccination campaign which is an additional ask on capacity.

Action owner: CAV Public Health Team

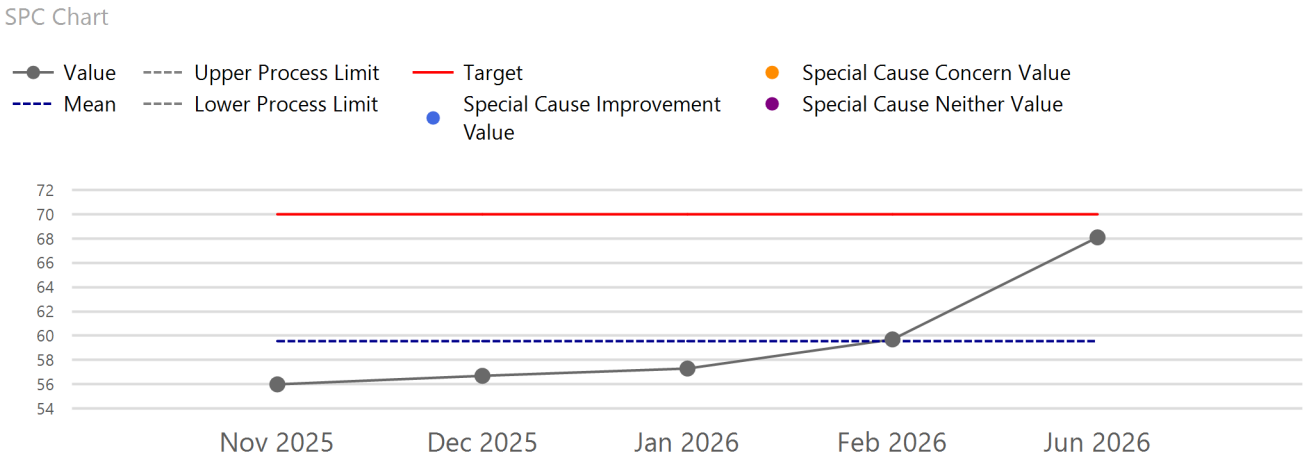
Concerns

Uptake was below the national target of 75%. There was a gap in uptake between the least and most deprived areas

Metric ID: 10000103

Percentage uptake of the Respiratory Syncytial Virus (RSV) for those turning 75 years old

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	68.1	70			Executive Director of Public Health



Narrative

The RSV vaccination programme was introduced 1 September 2024 for older adults as they turn 75 years old and pregnant women at 28 weeks' gestation.

As of June 2026, 2,699 out of 3,065 individuals reaching their 75th birthday between 1st September 2024 and 31st August 2025 2026 were vaccinated. This is an uptake of 68.1%, which is above the All-Wales average of 62.8%.

Actions and Owners

A 12-month, one-off catch-up campaign was introduced 1 September 2024 to target individuals aged between 75 and 79 years old. This one off catch up campaign was amended in August 2025 so these individuals would remain eligible indefinitely. The programme was expanded in April 2026 to include all adults aged 80+ and all residents in a care home for older adults.

Action owner: CAV Public Health Team

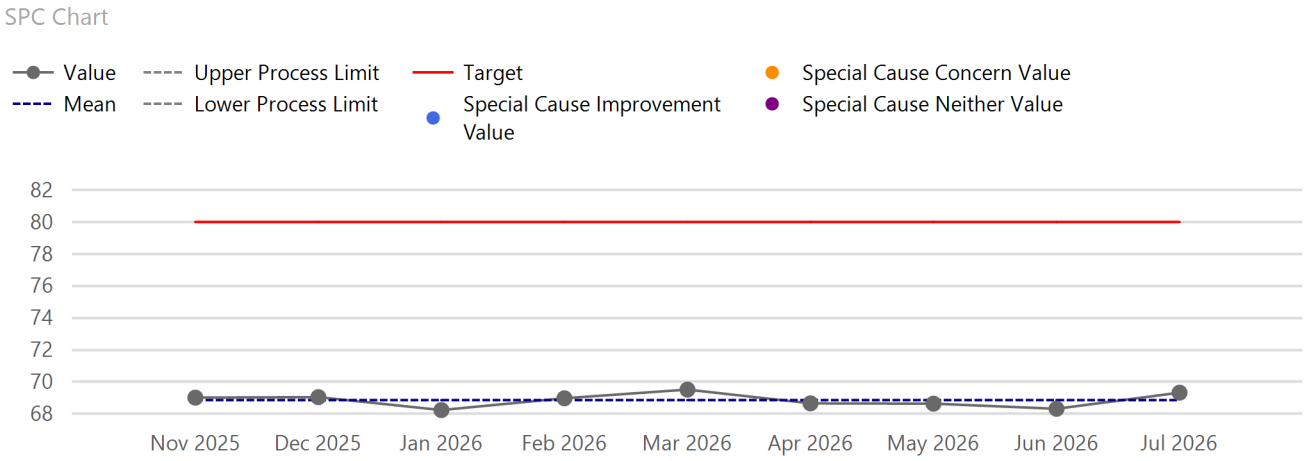
Concerns

Uptake for individuals reaching their 75th birthday is below the national target of 70%.

Metric ID: 10000104

Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within last 15 months

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	69.33	80			Executive Director of Public Health



Narrative

Slight increase over last month.

Actions and Owners

Primary Community and Intermediate Care (PCIC) Clinical Board are leading on 8 care process cluster work. They are looking at practice level data to identify and support lowest uptake practices, and providing practice-specific support and sharing best practice. Practice visits have taken place over Summer and into Autumn.

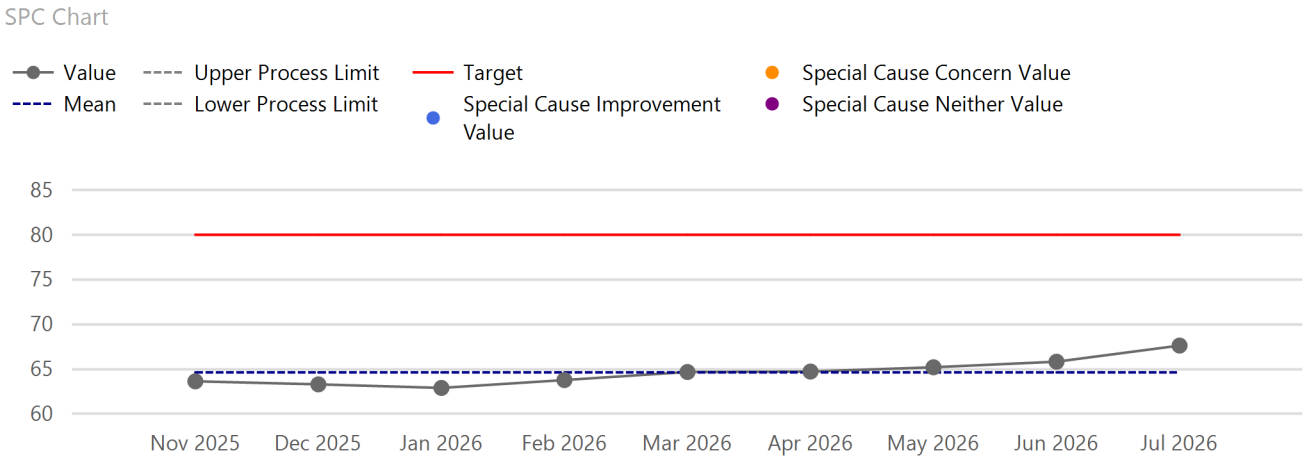
Concerns

None

Metric ID: 10000105

Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within last 15 months

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	67.63	80			Executive Director of Public Health



Narrative

Sustained increase since January 2026.

Actions and Owners

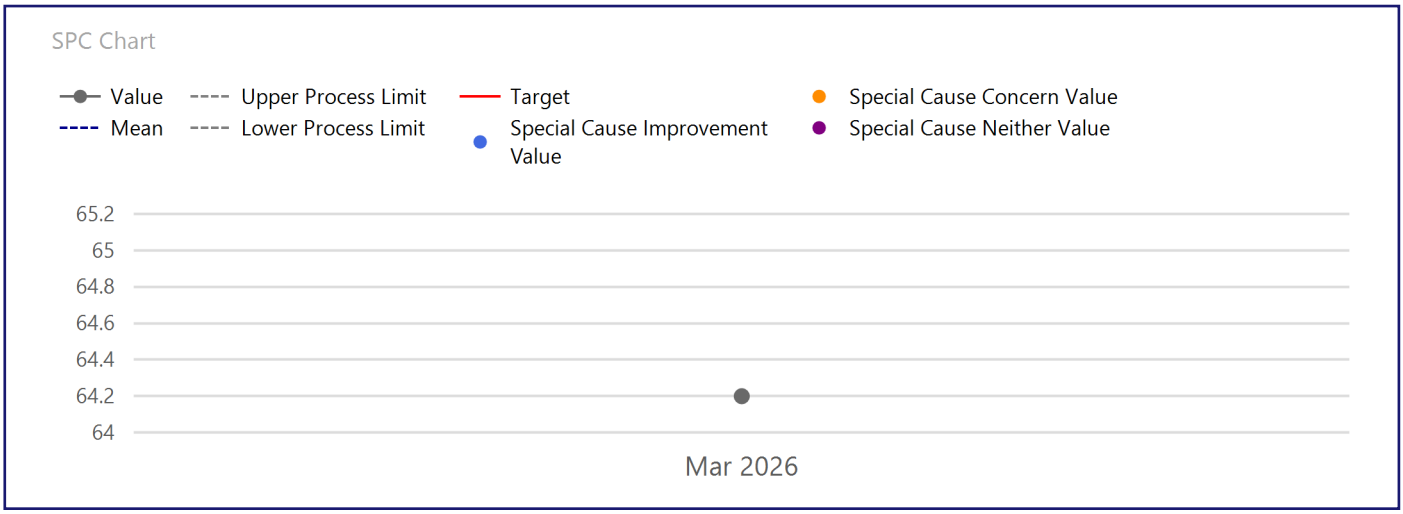
Primary Community and Intermediate Care (PCIC) Clinical Board are leading on 8 care process cluster work. They are looking at practice level data to identify and support lowest uptake practices, and providing practice-specific support and sharing best practice. Practice visits have taken place over Summer and into Autumn.

Concerns

None

Metric ID: 10000106 % uptake of flu vaccination among CAVUHB staff

Latest Month	Value	Target	Assurance	Variation	Metric Owner
March 2026	64.2	65			Executive Director of Public Health



Narrative

As part of the Autumn Influenza campaign we began vaccinating health and social care staff on 1 September 2026. CAVUHB incorporated a roaming delivery model for staff vaccination in 2025/26 and utilised an enhanced approach to communications. The public health team contributed to a national Influenza 2025/26 Lessons Learned process run by Vaccination Programme Wales (VPW) and ran a local evaluation and forward planning session.

Actions and Owners

Joint Health Board flu evaluation session held in April 2026, planning underway for the 2026/27 season.

Action owner: CAV Public Health Team

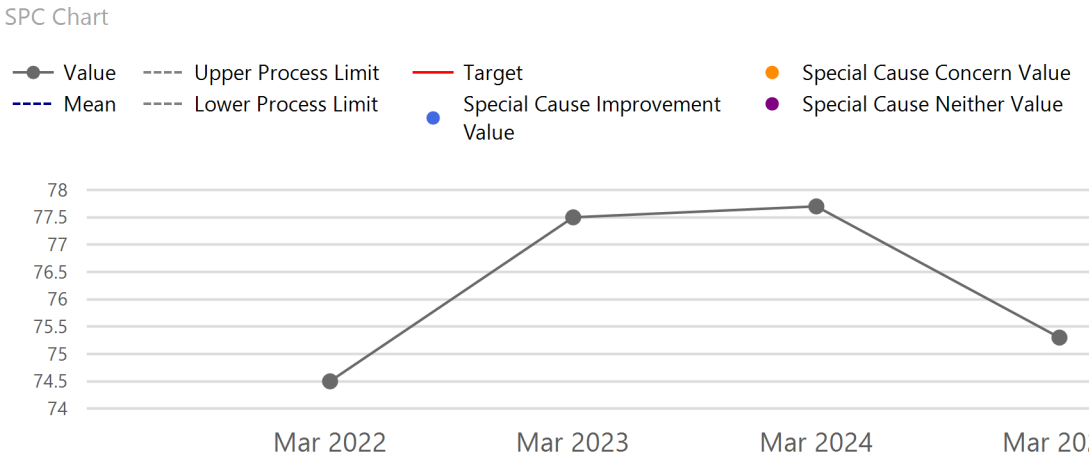
Concerns

No current concerns

Metric ID: 10000108

Prevalence of healthy weight children as measured by Child Measurement Programme (CMP)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
March 2025	75.3				Executive Director of Public Health



Narrative

2024/25 Child Measurement Programme data demonstrated a slight decrease in healthy weight to 75.3%, from 77.7% the previous year (for Cardiff and Vale UHB). The UHB had the highest level of healthy weight of all Welsh Health Boards for 2024/25.

There are no comparable data in other UK countries due to different methodologies being used.

Actions and Owners

Action is on track. Actions in Good Food and Movement Implementation Plan (2026-2028) agreed by both Cardiff and Vale of Glamorgan Governance structures.

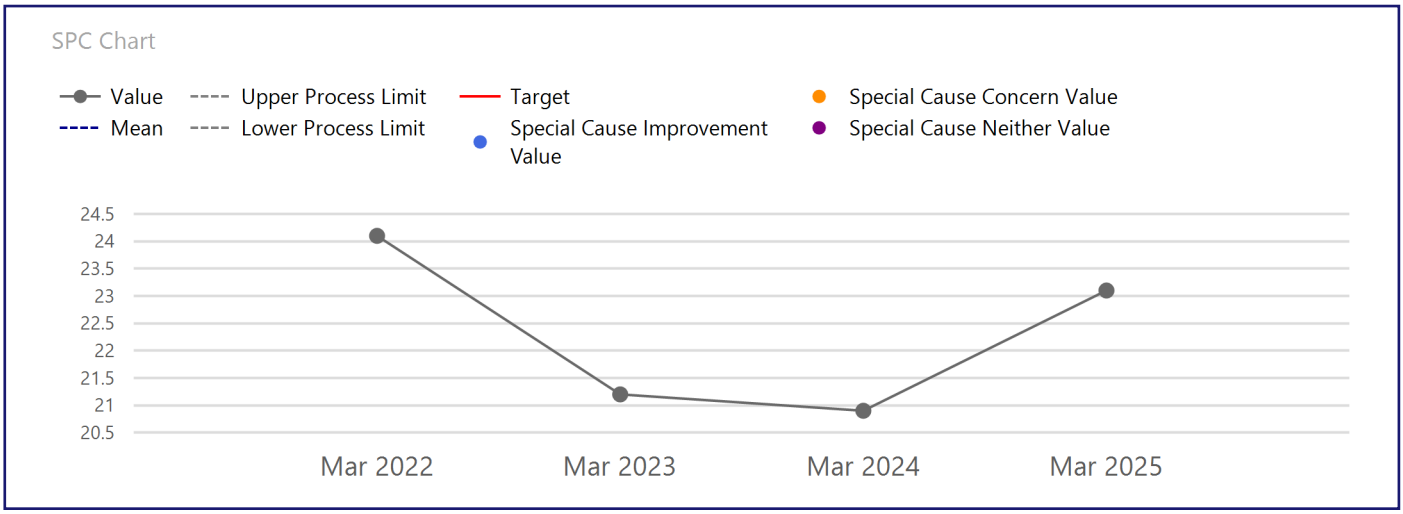
Action owner: CAV Public Health Team

Concerns

2024/25 Child Measurement Programme data demonstrated a slight decrease in healthy weight to 75.3%, from 77.7% the previous year (for Cardiff and Vale UHB).

Metric ID: 10000109 Decrease in overweight and obesity prevalence as measured by the CMP

Latest Month	Value	Target	Assurance	Variation	Metric Owner
March 2025	23.1				Executive Director of Public Health



Narrative

See 'healthy weight' indicator

Actions and Owners

Action is on track. Actions in Good Food and Movement Implementation Plan (2026-2028) agreed by both Cardiff and Vale of Glamorgan Governance structures.

Action owner: CAV Public Health Team

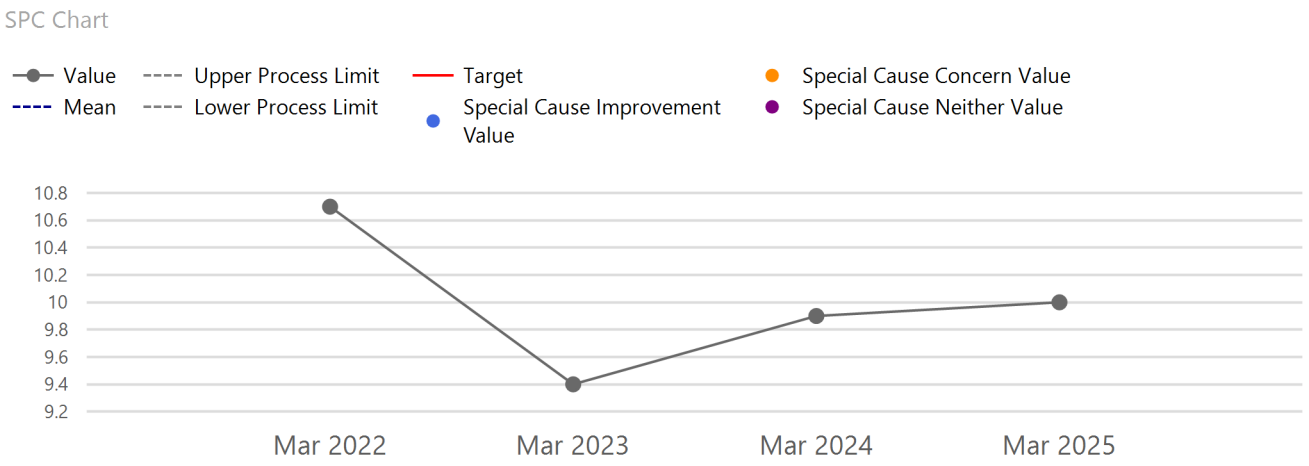
Concerns

No current concerns

Metric ID: 10000110

Decrease in the gap between most and least deprived reception year children for healthy weight, as measured by the CMP

Latest Month	Value	Target	Assurance	Variation	Metric Owner
March 2025	10				Executive Director of Public Health



Narrative

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.

Actions and Owners

Action is on track. Actions in Good Food and Movement Implementation Plan (2026-2028) agreed by both Cardiff and Vale of Glamorgan Governance structures.

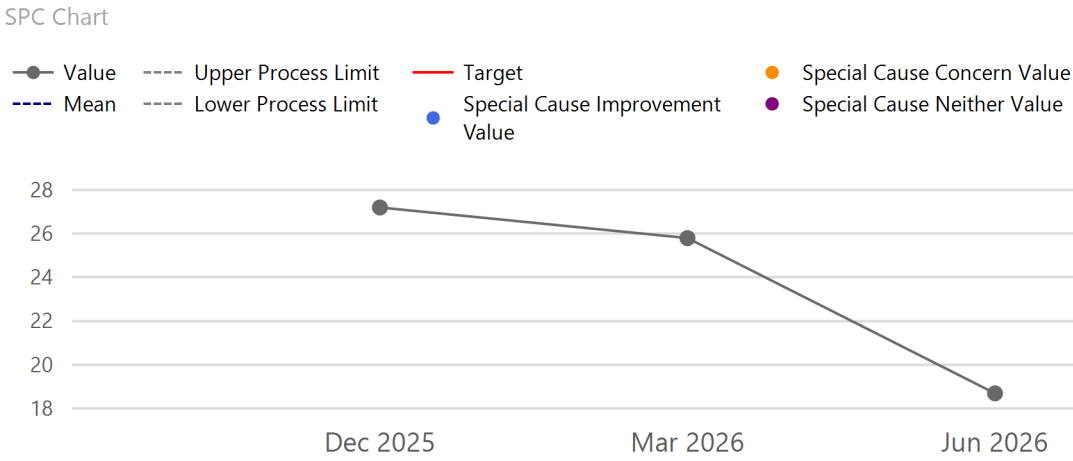
Action owner: CAV Public Health Team

Concerns

No current concerns

Metric ID: 10000111 Largest gap in uptake of 8 care processes at cluster level

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	18.7				Executive Director of Public Health



Narrative

Sustained increase in 8 care process completion over last three quarters for lowest completion rate cluster.
(Previous incorrect figure for Mar 26 revised to 25.8%)

Actions and Owners

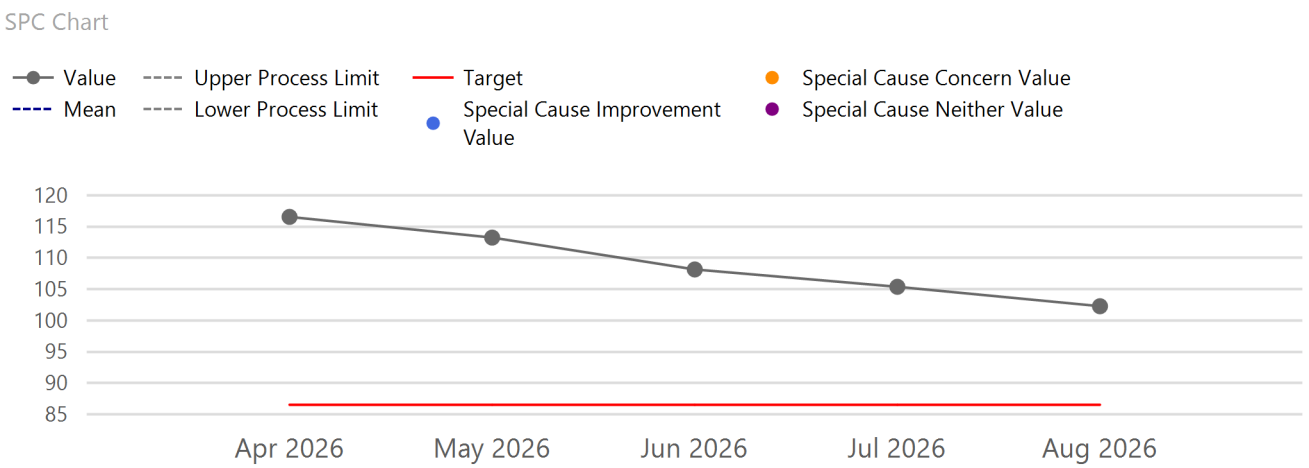
Primary Community and Intermediate Care (PCIC) Clinical Board are leading on 8 care process cluster work. They are looking at practice level data to identify and support lowest uptake practices, and providing practice-specific support and sharing best practice. Practice visits have taken place over Summer and into Autumn.

Concerns

Reduction in gap is also due to fall in care process completion rate from highest completion rate cluster.

Metric ID: 10000153 Deliver 2026/27 Draft Financial Plan - In Year

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	102.3	86.55	F		Executive Director of Finance



Narrative

The £86.5m planning deficit needs to be derisked at pace. At month 5 there was a £17.9m in year shortfall in risk assured against the core £42.5m savings target. £20.0m of red-rated schemes have been identified; however, at this stage the UHB does not have sufficient assurance regarding the level of delivery that will be achieved from these schemes within the current financial year.

There are not yet schemes in place to deliver the JCC £5.1m 2% efficiency target. Discussions and work are ongoing with the JCC in order to drive savings identification and delivery.

Actions and Owners

Executive-led turnaround meetings have been established with each Clinical Board and Service Board to support the delivery of both in-year target control totals and recurrent financial sustainability. These arrangements provide a structured forum for the identification and progression of mitigating actions, including the management of current and emerging operational pressures.

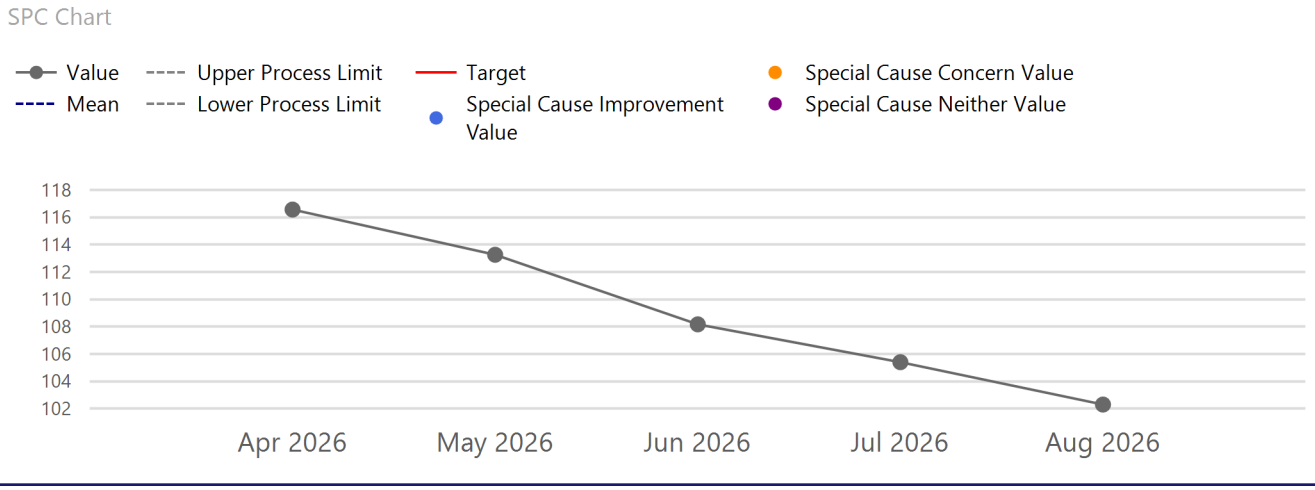
In addition, the UHB has engaged external consultants to build on and accelerate previously completed transformation work. The support is intended to provide assurance regarding the achievement of the planned 2026/27 deficit position, while also driving recurrent efficiencies and contributing to a sustainable reduction in the UHB's underlying deficit.

Concerns

Progress in developing and implementing additional savings plans must accelerate to ensure the UHB can achieve its planning deficit target of £86.5m

Metric ID: 10000154 Return to financial balance and approved IMTP status

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	102.3				Executive Director of Finance



Narrative

The UHB is forecast to breach its statutory three-year break even duty. Ongoing delivery of savings plans and financial control measures are essential to improving the financial position over the medium term.

Actions and Owners

Executive-led turnaround meetings have been established with each Clinical Board and Service Board to support the delivery of both in-year target control totals and recurrent financial sustainability. These arrangements provide a structured forum for the identification and progression of mitigating actions, including the management of current and emerging operational pressures.

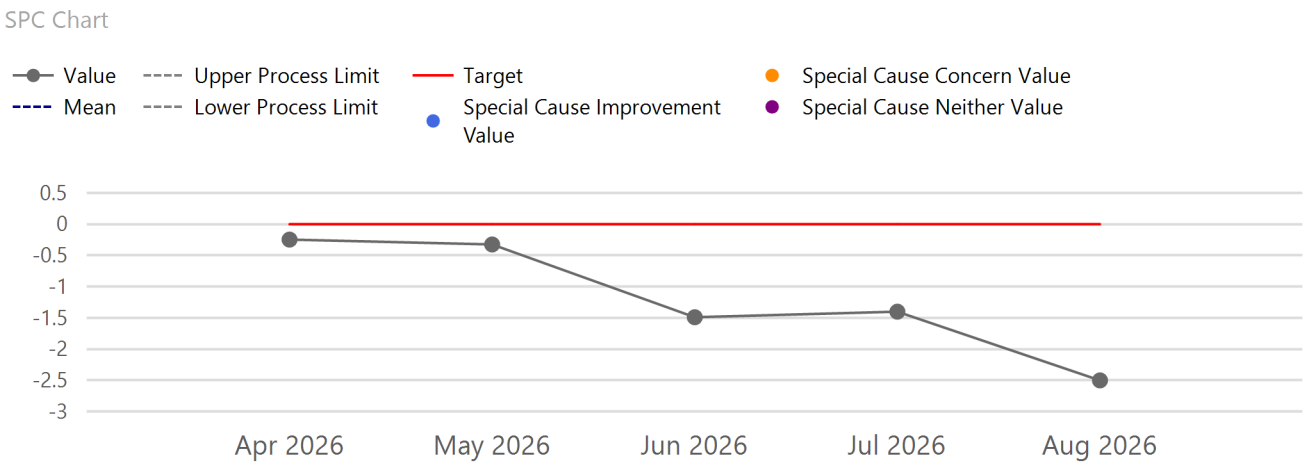
In addition, the UHB has engaged external consultants to build on and accelerate previously completed transformation work. The support is intended to provide assurance regarding the achievement of the planned 2026/27 deficit position, while also driving recurrent efficiencies and contributing to a sustainable reduction in the UHB's underlying deficit.

Concerns

Based on the current forecast, the UHB is not expected to achieve its statutory break even duty and will require additional financial support from Welsh Government.

Metric ID: 10000155 Management of operational budget pressures

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	-2.5	0	P		Executive Director of Finance



Narrative

The UHB is reporting an overspend of £43.1m, comprising a planned deficit of £36.1m, representing five twelfths of the £86.5m deficit set out in the UHB's Financial Plan, together with an £9.6m shortfall against the savings programme. This is partially offset by an operational surplus of (£2.5m).

Actions and Owners

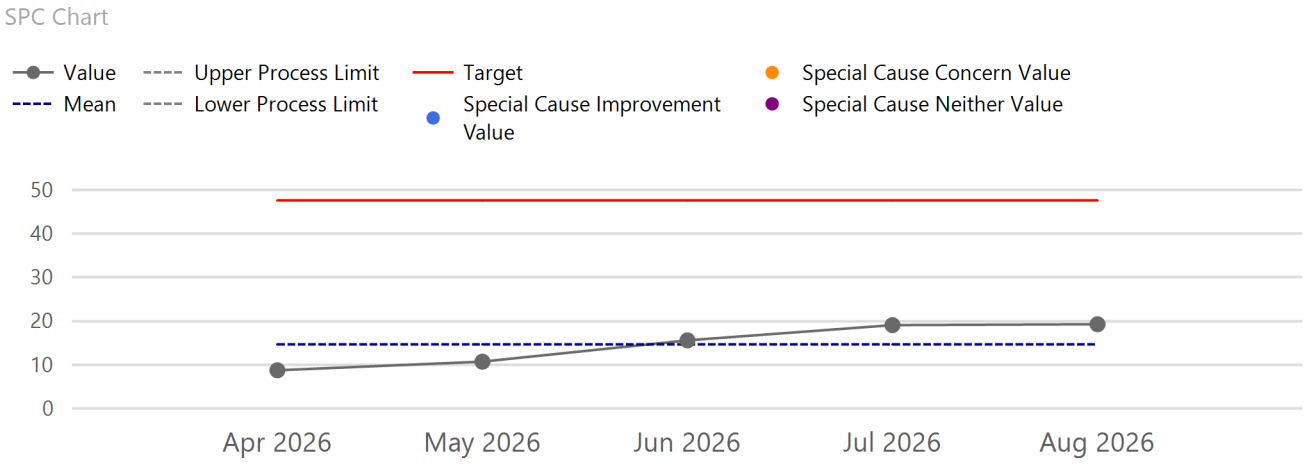
It is expected that all unplanned cost pressures arising during 2026/27 will be matched by corresponding mitigating actions, enabling the UHB to deliver the planned deficit of £86.5m as set out in the submitted Financial Plan.

Concerns

The operational surplus is primarily driven by workforce vacancies and is partially mitigating the impact of the identified savings shortfall.

Metric ID: 10000156 Delivery of recurrent savings target

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	19.3	47.61			Executive Director of Finance



Narrative

£19.3m of recurrent savings were identified at month 4 leaving a gap of £23.2m against the £42.5m core recurrent target. There are not yet schemes in place to deliver the JCC £5.1m 2% efficiency target.

Actions and Owners

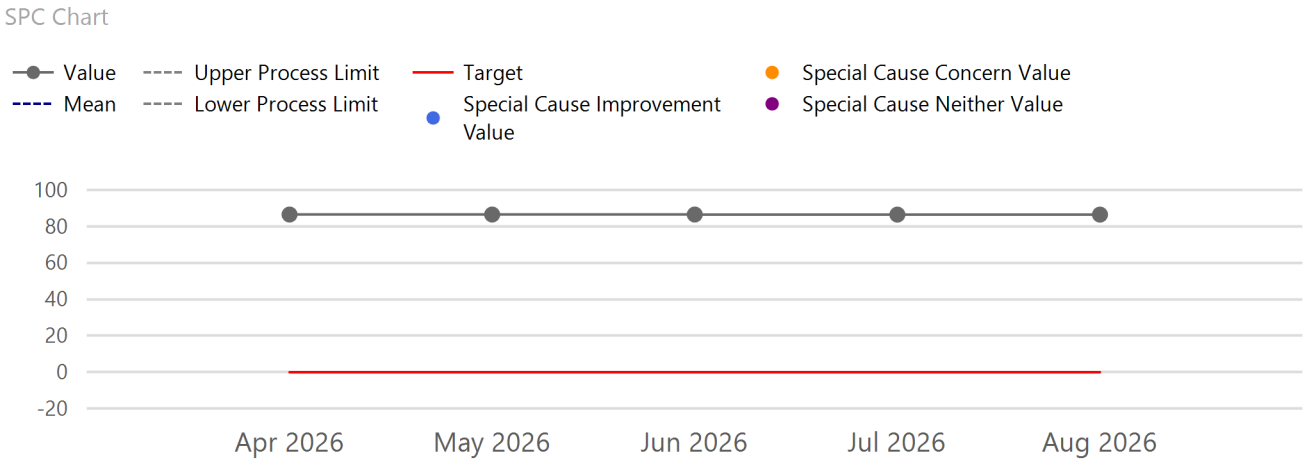
Further action is required to meet the recurrent targets and the UHB will continue to press all parts of the organisation to agree urgent actions that will accelerate savings to mitigate the ongoing risk.

Concerns

A gap of £23.2m is currently reported against the £42.5m core recurrent savings target. In addition, a further £5.1m shortfall is reported against the JCC efficiency target. In the absence of further mitigating actions, these shortfalls will increase the UHB's underlying deficit and place additional recurrent financial pressure on the organisation as it enters the next financial year.

Metric ID: 10000157 Remain within Cash Limit

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	86.5	0	F		Executive Director of Finance



Narrative

In due course, the UHB expects to seek Finance Committee and Board approval to request £86.5m strategic cash support from Welsh Government to cover the cash shortfall arising from the forecast deficit.

Actions and Owners

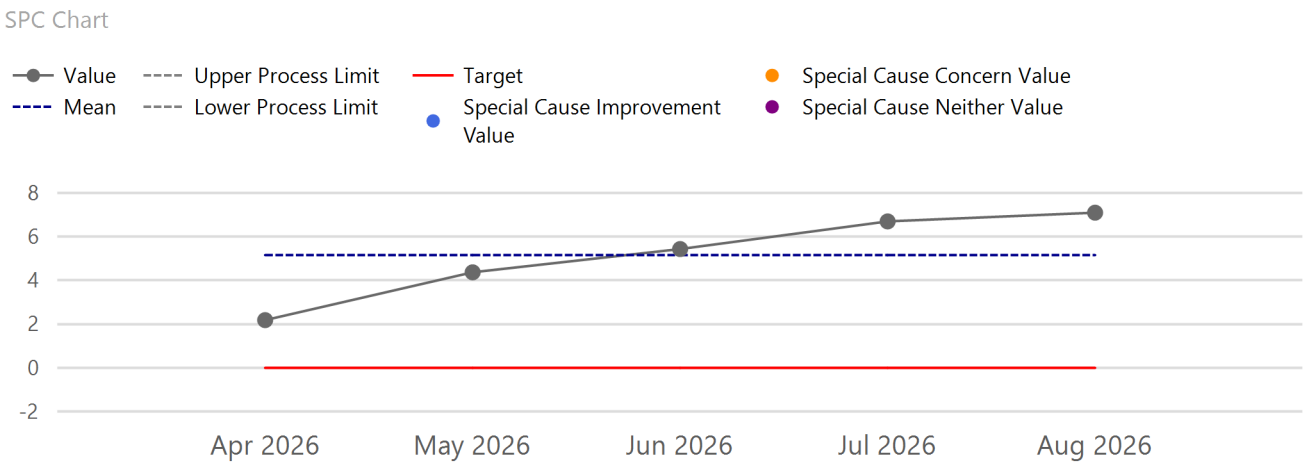
Options to manage cash pressures include accelerating the delivery of savings schemes, strengthening expenditure controls, reviewing and re-phasing capital expenditure where appropriate, maximising the recovery of income and debtors, and actively managing working capital. The UHB will continue to monitor its cash position closely and work with Welsh Government to ensure sufficient liquidity is maintained throughout the year.

Concerns

The UHB's strategic cash requirement is primarily driven by its forecast deficit. Any deficit incurred in excess of the forecast position will increase the UHB's cash requirement and place further pressure on cash management arrangements.

Metric ID: 10000158 Deliver 2026/27 Draft Financial Plan (in month)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	7.1	0			Executive Director of Finance



Narrative

Year to date operational pressures in medical endoscopy, mental health Out of Area (OoA) patients, specialist medical locums, fall in private patient demand offset by pay vacancies, medicines management savings and commissioning performance. In addition, there remains a shortfall in recurrent and in year schemes identified to deliver the planned savings target.

Actions and Owners

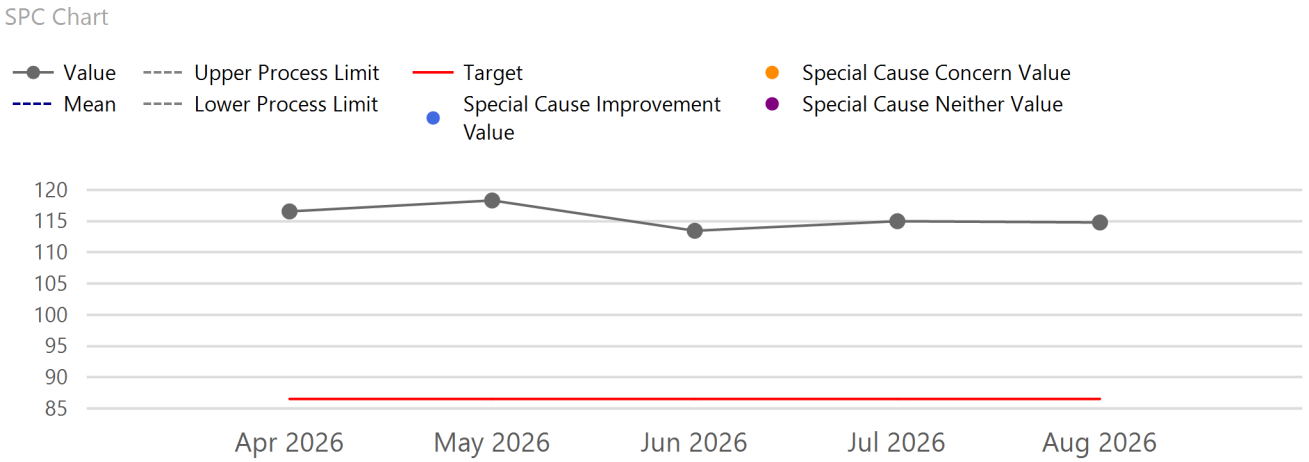
Executive-led turnaround meetings have been established with each Clinical Board and Service Board to support the delivery of both in-year target control totals and recurrent financial sustainability. These arrangements provide a structured forum for the identification and progression of mitigating actions, including the management of current and emerging operational pressures.
In addition, the UHB has engaged external consultants to build on and accelerate previously completed transformation work. The support is intended to provide assurance regarding the achievement of the planned 2026/27 deficit position, while also driving recurrent efficiencies and contributing to a sustainable reduction in the UHB's underlying deficit.

Concerns

It is expected that all unplanned cost pressures arising in 2026/27 will have corresponding mitigations identified to deliver the submitted £86.5m planned deficit. In addition, the full savings target is expected to be delivered through the implementation of identified efficiency schemes and further mitigation measures where required.

Metric ID: 10000159 Deliver 2026/27 Draft Financial Plan - Underlying Deficit

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	114.8	86.55	F		Executive Director of Finance



Narrative

If the gap against the recurrent savings plan is not closed and operational pressures are not effectively managed during the year, the underlying deficit (ULD) will increase materially. This position can only be mitigated through the identification and implementation of robust and sustainable cost reduction measures and other mitigating actions.

Actions and Owners

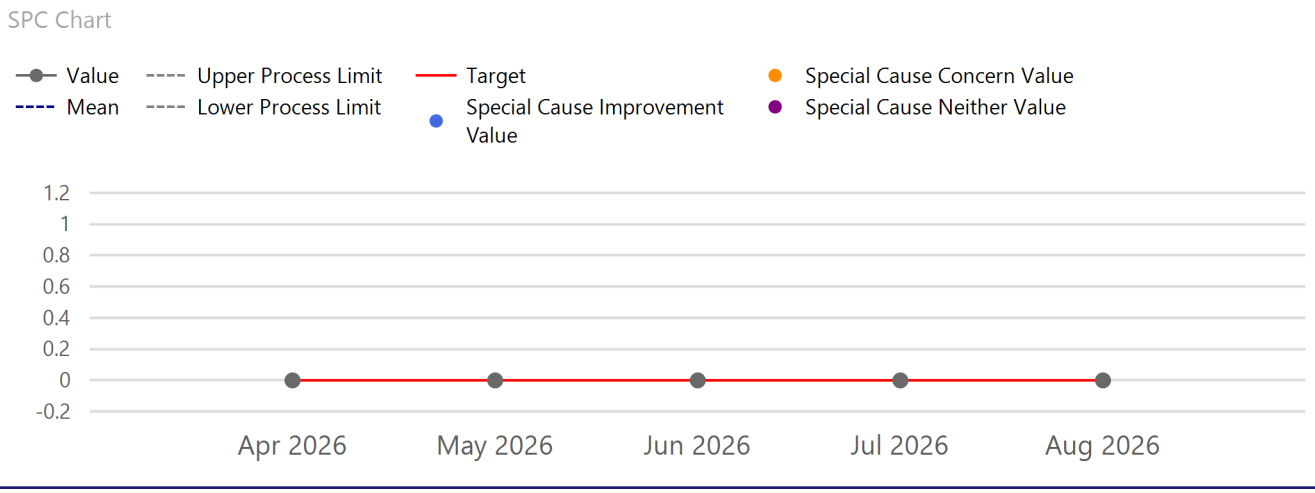
Executive-led turnaround meetings have been established with each Clinical Board and Service Board to support the delivery of both in-year target control totals and recurrent financial sustainability. These arrangements provide a structured forum for the identification and progression of mitigating actions, including the management of current and emerging operational pressures.
In addition, the UHB has engaged external consultants to build on and accelerate previously completed transformation work. The support is intended to provide assurance regarding the achievement of the planned 2026/27 deficit position, while also driving recurrent efficiencies and contributing to a sustainable reduction in the UHB's underlying deficit.

Concerns

The UHB's underlying deficit (ULD) has deteriorated in recent years due to a combination of; underlying deficit brought forward; recurrent cost pressures (including inflation); under delivery of recurrent savings and demand-driven pressures in 2025/26.

Metric ID: 10000160 Achievement of capital statutory breakeven duty

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	0	0	P		Executive Director of Finance



Narrative

As at 31 August 2026, the UHB's approved Capital Resource Limit (CRL) was £46.8m, of which 8% had been expended. Capital expenditure is currently forecast to remain within the approved CRL, with all planned schemes expected to be delivered within the available funding envelope, resulting in a projected year-end variance of nil against the CRL.

Actions and Owners

The Capital Management Group monitors and approves the UHB's capital expenditure plans.

Concerns

There has been a slight delay in the commencement of a number of schemes in 2026/27. The Health Board continues to engage with Welsh Government colleagues regarding a proposed £1.9m reduction in Capital Resource Limit (CRL) funding for the Park View Health and Wellbeing Hub scheme, reflecting anticipated slippage in expenditure during 2026/27.

Metric ID: 10000036 Percentage of sickness absence rate of staff (In-month)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	6.1026	5.5			Executive Director of People and Culture

Narrative

The in-month sickness absence rate was 6.10% in August 2026, compared with 5.80% in April, and remains above the UHB target of 5.50%. The position is, however, better than August 2025, when the rate was 6.24%. Unless the SPC chart identifies a special-cause signal, the variation should be treated as common cause, requiring continued system-level improvement combined with targeted action in hotspot areas.

Actions and Owners

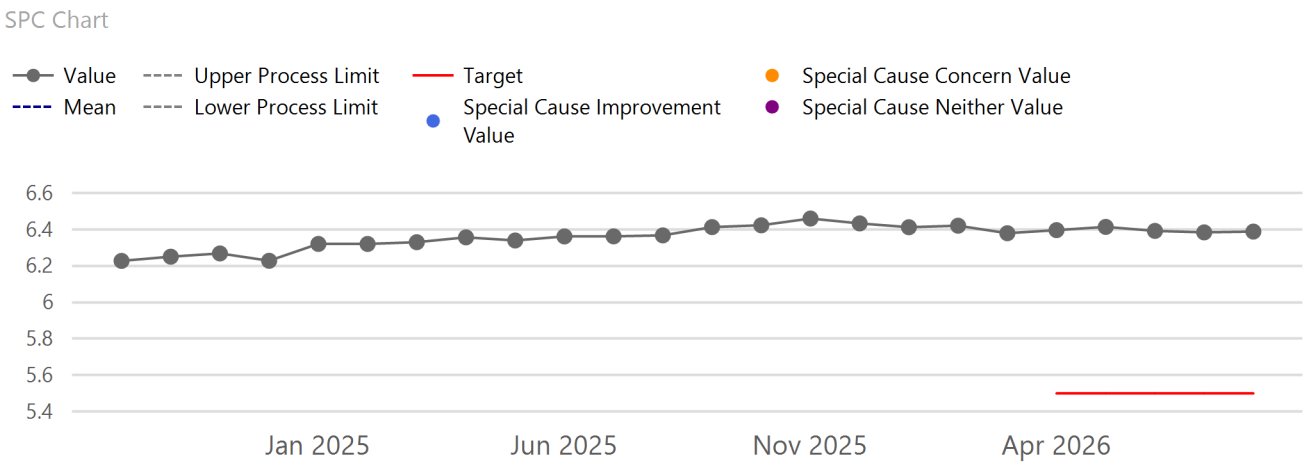
Further grip is still required, particularly on long-term absence, stress-related absence, data quality and timely case progression. The focus will be on scaling what works, strengthening Managing Attendance at Work compliance, preparing for winter pressures and improving insight to support prevention.

Concerns

Performance remains above target. There is limited assurance that current improvement will be sustained without stronger Clinical Board recovery trajectories, consistent attendance-management practice and demonstrable impact from targeted interventions. There is evidence that targeted intervention is making a difference, with improvements seen in numerous areas, some of these are identified in the report. Focused case management, sickness workshops, attendance panels and management coaching as well as additional signposting and wellbeing for staff have supported with these improvements.

Metric ID: 10000037 Percentage of sickness absence rate of staff (12-month cumulative)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	6.3883	5.5	F		Executive Director of People and Culture



Narrative

The 12-month cumulative sickness absence rate remains above the organisational target of 5.5%, with the latest reported position at approximately 6.4%. The SPC chart demonstrates a stable pattern of variation with no evidence of significant special cause improvement or deterioration during the reporting period. Following a gradual increase during 2025, absence levels have remained consistently elevated throughout 2026.

Whilst the absence rate has stabilised in recent months, performance continues to be materially above target, indicating that sickness absence remains an ongoing workforce challenge. The absence trajectory suggests that current interventions may be mitigating further deterioration but have not yet delivered the sustained improvement required to achieve the target level.

Actions and Owners

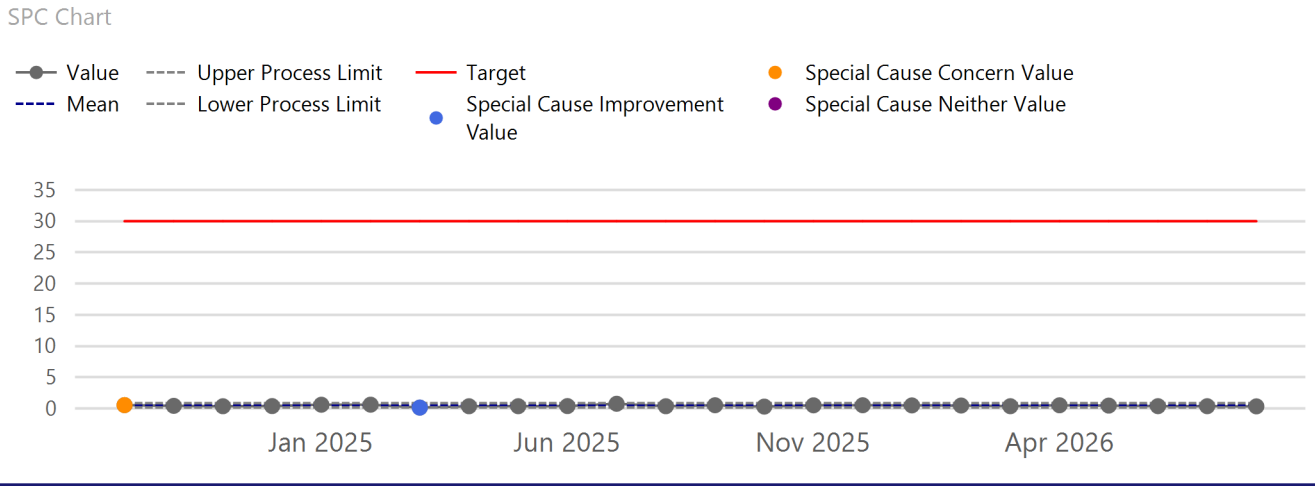
Continue targeted hotspot reviews within services reporting sickness absence above UHB average. Strengthen compliance monitoring of Managing Attendance at Work policy, including trigger meetings, return to work interviews and case reviews.

Concerns

Continued focus is required on reducing long-term absence, improving attendance management compliance, and targeting support within areas demonstrating the highest absence rates. Given the cumulative nature of the measure, any improvement actions undertaken are likely to take several months before generating a significant downward shift in the reported metric.

Metric ID: 10000039 Agency spend as a percentage of the total pay bill.

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	0.3689	30	P		Executive Director of People and Culture



Narrative

Agency spend as a percentage of the total pay bill was 0.37% in August 2026, with the SPC chart indicating common cause variation. This suggests that performance is stable, predictable and operating within expected limits, with no evidence of unusual variation or deterioration in agency reliance. The Health Board continues to demonstrate strong control of agency expenditure, reflecting ongoing workforce management actions, effective deployment of substantive staff, and reduced reliance on temporary staffing solutions. The current position provides a high level of assurance that agency expenditure is being effectively managed and is supporting the organisation's financial recovery objectives

Actions and Owners

Continue monthly monitoring of agency expenditure by Clinical Board, Directorate and staff group to identify emerging hotspots and address any upward trends at the earliest opportunity.
Ensure vacancies are actively reviewed through workforce planning and recruitment control processes, with priority given to substantive recruitment and alternative staffing solutions where appropriate.
Maintain scrutiny of agency usage through established financial recovery and workforce governance arrangements.
Support Clinical Boards to maximise bank utilisation and workforce redesign opportunities before agency engagement is approved.
Regularly review high-spend areas and require recovery plans where agency expenditure begins to increase beyond expected limits.

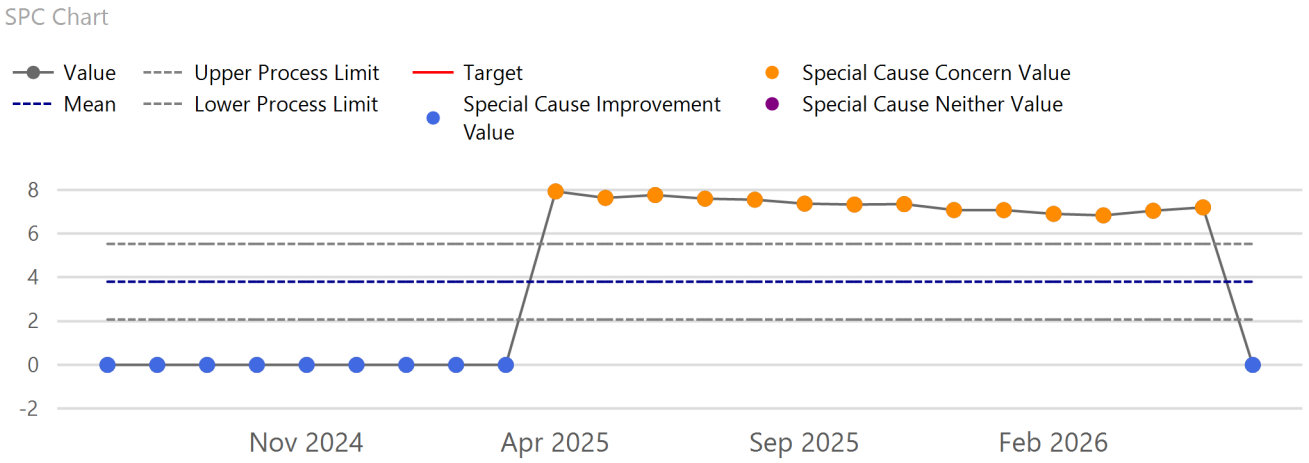
Concerns

Although performance remains favourable, the SPC chart demonstrates a stable pattern rather than continued improvement, indicating that further reductions may become increasingly difficult to achieve without addressing underlying workforce supply challenges.
Ongoing workforce pressures, recruitment challenges, sickness absence, or service demand increases could result in renewed reliance on agency staffing if not actively managed.
Continued vigilance is required to ensure compliance with national and local controls on agency expenditure and to prevent cost pressures emerging in high-risk service areas.
Any deterioration in substantive workforce availability could quickly impact agency utilisation and expenditure levels.

Metric ID: 10000074

Turnover rate for nurse, midwifery, medical and dental registered staff leaving NHS Wales

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	0				Executive Director of People and Culture



Narrative

HEIW publish this data on a quarterly basis. The narrative below is the same as reported previously, this will be updated when a refresh of the data is provided.

The SPC chart indicates that the turnover rate for nursing, midwifery, medical and dental registered staff leaving NHS Wales remains below the 7–9% target range, with the latest reported value for June 2026 at 0.0. The chart is showing improvement/low variation, suggesting that the metric is not currently demonstrating adverse movement; however, the very low reported position may need to be interpreted with caution due to known data quality limitations in recording future employment destination on termination forms.

Actions and Owners

- Reinforce to managers the importance of accurately completing termination forms/SMA, particularly the future employment destination field.
- Strengthen communication with managers and People & Culture Business Partners to improve compliance and consistency of recording.
- Review data completeness on a monthly basis to identify areas where termination forms are incomplete or inconsistently recorded.
- Use improved leaver destination data to support retention analysis and identify any emerging workforce risks or themes.

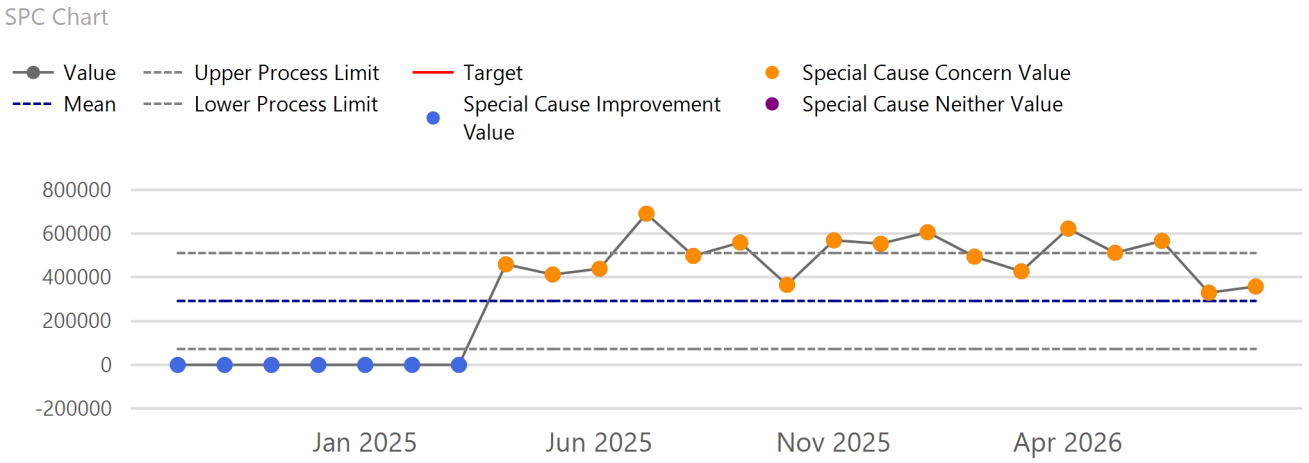
Owner: Workforce Information Team/People Analytics Team

Concerns

- The turnover rate is currently below the expected 7–9% target range, although this may not fully reflect the true position due to incomplete capture of staff destination data.
- There is a data quality concern: the organisation does not have an accurate picture of leavers' future employment because this relies on managers completing the relevant section of the termination form/SMA.
- This limits the ability to understand whether staff are leaving for other NHS Wales organisations, non-NHS employment, retirement, career progression, or other reasons.

Metric ID: 10000075 Agency Spend

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	358596			H	Executive Director of People and Culture



Narrative

Agency expenditure remains above the trajectory required to achieve the Welsh Government target of a 30% reduction. Whilst expenditure reduced in July to £330k, this position should be interpreted with caution as it includes the reclassification of Radiology insourcing costs rather than a wholly recurrent reduction in agency utilisation. Agency costs increased to £358k in August 26 and was below the monthly ceiling of £374k. However, cumulative spend to Month 5 remains £522k above the profiled ceiling required to deliver the annual target.

Actions and Owners

Continued executive scrutiny and conversion of agency workers to bank or substantive employment will be required if the Health Board is to recover the year-to-date variance and achieve the full 30% reduction target.

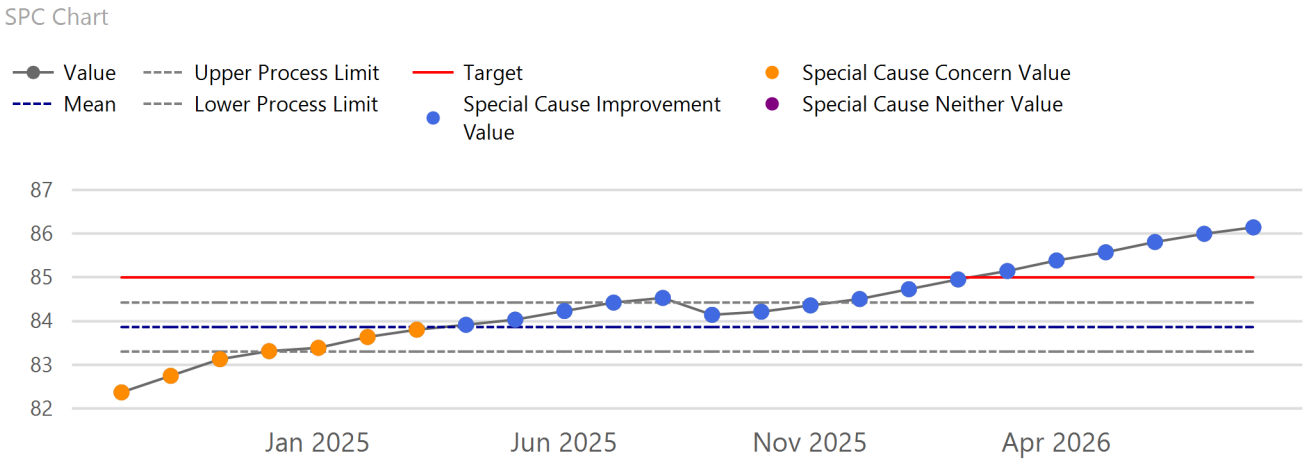
Agency expenditure should be reviewed by the clinical boards to Progress should be reviewed monthly using the SPC chart, with any special-cause variation or sustained adverse movement investigated and supported by named actions, owners and delivery dates.

Concerns

Jul–Aug show improvement, but the current full-year forecast remains materially above the 30% reduction ceiling.

Metric ID: 10000076 Equality Data Provision - Disability

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	86.1452	85	F	H	Executive Director of People and Culture



Narrative

Disability data completeness continues to improve, increasing from 85.81% in June 2026 to 86.15% in August 2026, an improvement of 0.34%. Performance remains above the organisational target of 85%, providing increased confidence in the completeness of the dataset.
The sustained positive direction suggests that existing workforce processes, including staff engagement, onboarding and routine prompts to review equality information, are supporting improved data completeness. More complete disability information strengthens workforce equality reporting and supports a better understanding of workforce representation and staff experience.

Actions and Owners

Embed equality monitoring discussions into routine staff conversations, appraisals and onboarding processes.
Owner: Clinical & Service Board Leads / Line Managers

Monitor compliance at service level and target support to low-performing areas.

Owner: Equality & Inclusion Team/People Analytics Team

Continue communications to improve understanding of how disability data is used to support staff and reasonable adjustments.

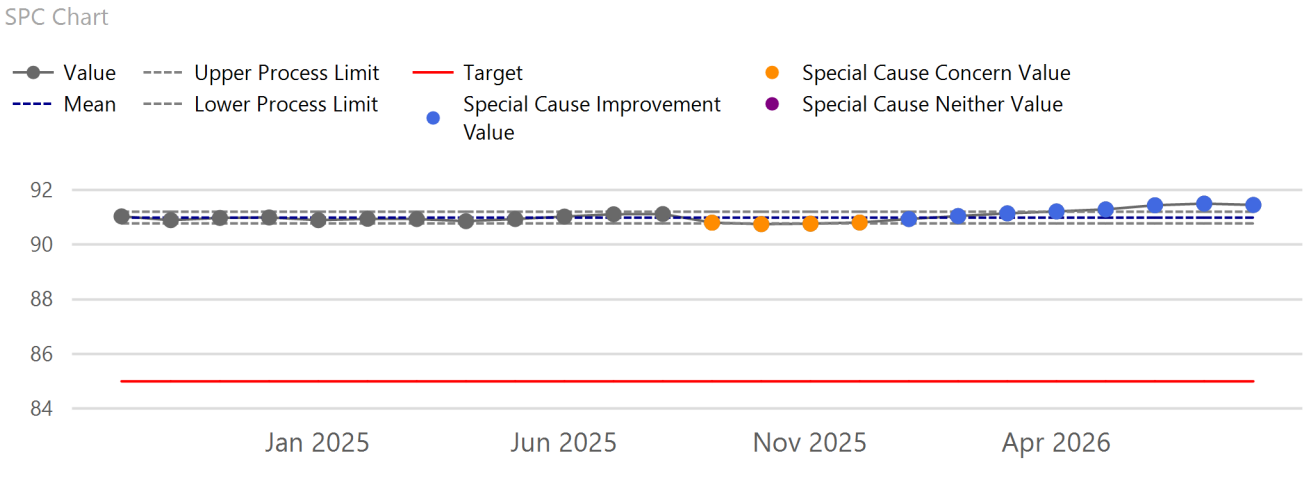
Owner: Equality & Inclusion Team

Concerns

Whilst performance is above target, approximately 14% of staff have not disclosed disability status. As disability remains a sensitive disclosure area, there is a risk that improvement may plateau without further targeted engagement. Incomplete data may also limit the accuracy of Workforce Equality Standard reporting and understanding of staff experience.

Metric ID: 10000077 Equality Data Provision - Ethnicity

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	91.4533	85	P	H	Executive Director of People and Culture



Narrative

Ethnicity data completeness remains strong, increasing marginally from 91.44% in June 2026 to 91.45% in August 2026. Performance remains 6.45% above the organisational target of 85%.
The consistently high completion rate indicates that ethnicity data collection is well embedded within workforce processes and provides a strong foundation for workforce planning and Workforce Race Equality Standard reporting. However, high data completeness does not in itself demonstrate equality of workforce outcomes, and the data must continue to inform action on representation, experience and progression.

Actions and Owners

Embed equality monitoring discussions within onboarding, appraisal and routine manager conversations.

Owner: Clinical & Service Board Leads / Line Managers

Monitor compliance at service and Clinical Board level, escalating areas of lower performance.

Owner: Equality & Inclusion Team/People Analytics Team

Continue targeted communications to reinforce the purpose and value of ethnicity data collection.

Owner: Equality & Inclusion Team

Following achievement of the Welsh language skills target, increase focus on improving completeness across all equality monitoring datasets

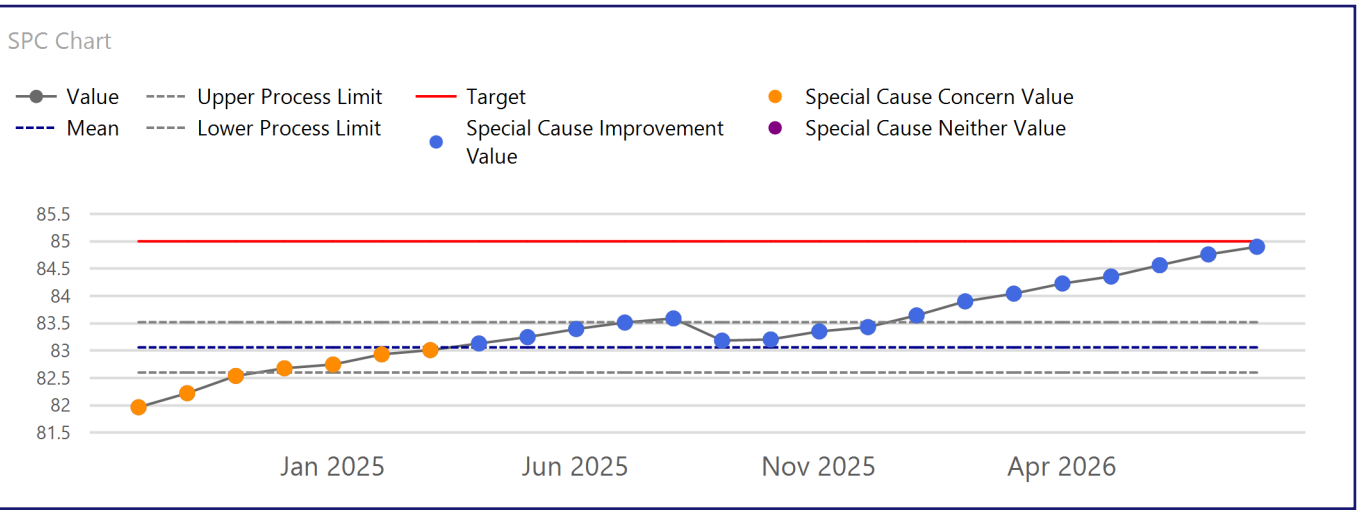
Owner: Equality & Inclusion Team

Concerns

Performance has plateaued, with approximately 9% of staff not declaring ethnicity. This may indicate that existing approaches have reached the limits of their effectiveness, and pockets of lower completion may be masked within organisational-level reporting. Incomplete data may reduce the accuracy of future WRES reporting and limit understanding of workforce representation and experience.

Metric ID: 10000078 Equality Data Provision - Religion

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	84.9	85	F	H	Executive Director of People and Culture



Narrative

Religion and belief data completeness increased from 84.56% in June 2026 to 84.90% in August 2026, an improvement of 0.34%. Performance is now only 0.10% below the organisational target of 85%.
The direction of travel remains positive and suggests that existing workforce processes and engagement activity are supporting gradual improvement. Greater completeness strengthens the reliability of workforce equality reporting and understanding of workforce demographics.

Actions and Owners

Embed equality monitoring discussions within onboarding, appraisal and routine manager conversations.

Owner: Clinical & Service Board Leads / Line Managers

Monitor compliance at service and Clinical Board level, escalating areas of lower performance.

Owner: Equality & Inclusion Team/People Analytics Team

Continue communications to reinforce the purpose, confidentiality and value of religion and belief data collection.

Owner: Equality & Inclusion Team

Following achievement of the Welsh language skills target, increase focus on improving completeness across all equality monitoring datasets.

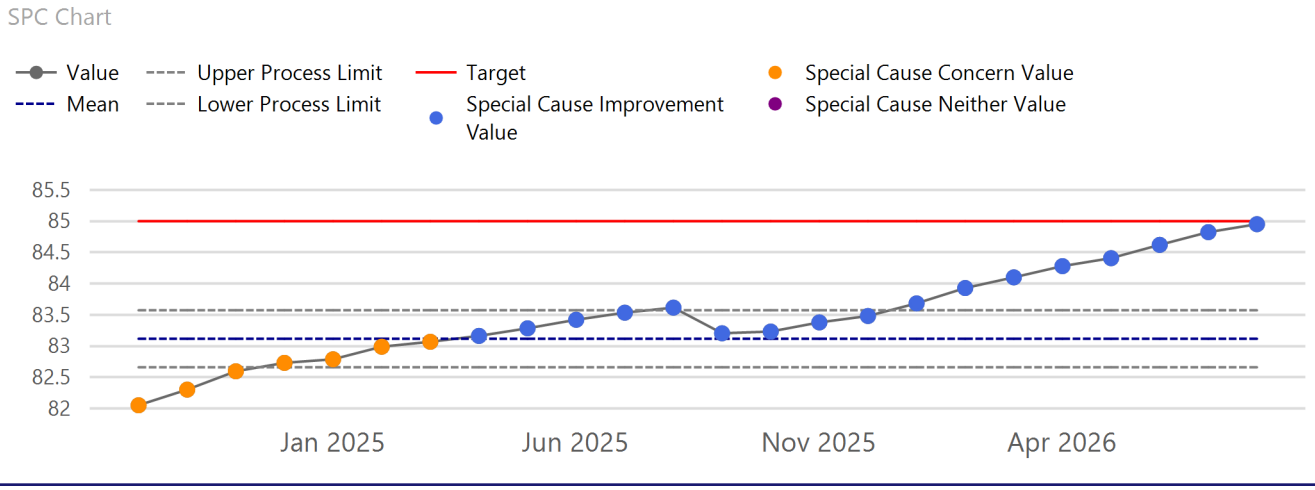
Owner: Equality & Inclusion Team

Concerns

Whilst performance continues to improve, approximately 15% of staff have not declared their religion or belief status. Religion remains a sensitive disclosure area, and concerns relating to relevance, confidentiality or personal choice may continue to limit completion rates. Without further targeted interventions, improvement is likely to remain gradual, potentially affecting the completeness and reliability of workforce equality reporting.

Metric ID: 10000079 Equality Data Provision - Sexual Orientation

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	84.9527	85	F	H	Executive Director of People and Culture



Narrative

Sexual orientation data completeness increased from 84.62% in June 2026 to 84.95% in August 2026, an improvement of 0.33%. Performance is now only 0.05% below the organisational target of 85%.
The sustained upward movement suggests that workforce processes and engagement activity are supporting improved data completeness. Improved information strengthens the reliability of workforce equality reporting and the Health Board's understanding of workforce diversity and staff experience.

Actions and Owners

Embed equality monitoring discussions within onboarding, appraisal and routine manager conversations.

Owner: Clinical & Service Board Leads / Line Managers

Monitor compliance at service and Clinical Board level, escalating areas of lower performance.

Owner: Equality & Inclusion Team/People Analytics Team

Continue targeted communications to reinforce the purpose, confidentiality and value of sexual orientation data collection.

Owner: Equality & Inclusion Team

Following achievement of the Welsh language skills target, increase focus on improving completeness across all equality monitoring datasets.

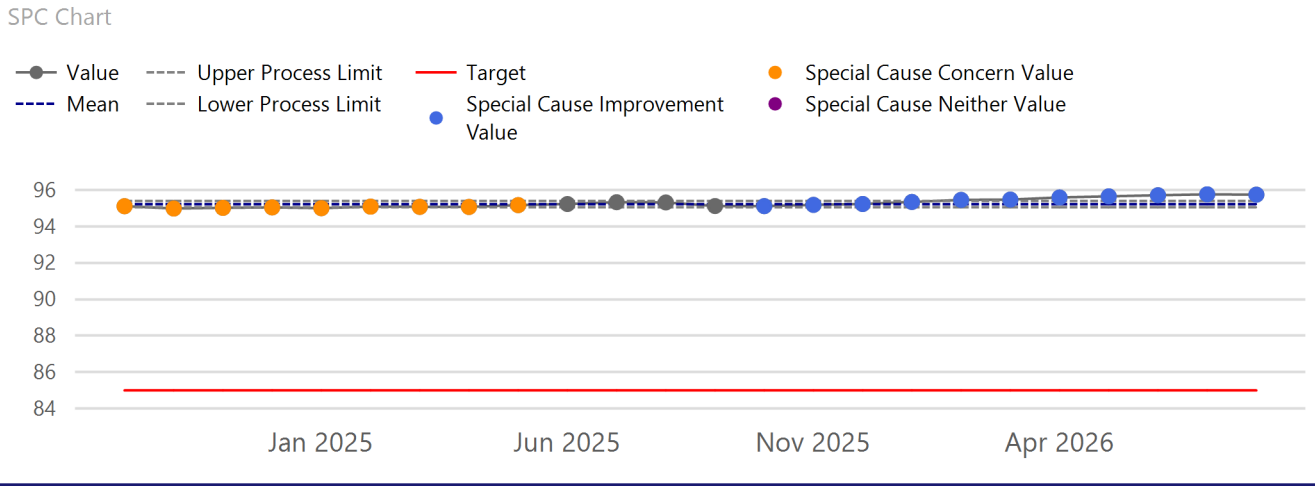
Owner: Equality & Inclusion Team

Concerns

Whilst performance continues to improve, approximately 15% of staff have not declared their sexual orientation. As this remains a sensitive disclosure area, progress may plateau without further targeted engagement to build confidence in the purpose, use and confidentiality of the data. Incomplete data may also limit the reliability of workforce equality reporting and understanding of staff experience.

Metric ID: 10000080 Equality Data Provision - Marital Status

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	95.7442	85	P	H	Executive Director of People and Culture



Narrative

Marital status remains one of the highest-performing equality monitoring dataset, increasing slightly from 95.71% in June 2026 to 95.74% in August 2026. Performance remains 10.74% above the organisational target of 85%.
The consistently high level of completion provides strong assurance regarding the quality of the dataset and supports reliable workforce reporting and analysis. Existing collection processes appear to be well embedded and should be maintained.

Actions and Owners

Embed equality monitoring discussions within onboarding, appraisal and routine manager conversations.

Owner: Clinical & Service Board Leads / Line Managers

Monitor compliance at service and Clinical Board level, escalating areas of lower performance where required.

Owner: Equality & Inclusion Team/People Analytics Team

Maintain existing processes and communications that support high levels of data completeness.

Owner: Equality & Inclusion Team

Following achievement of the Welsh language skills target, increase focus on improving completeness across all equality monitoring datasets.

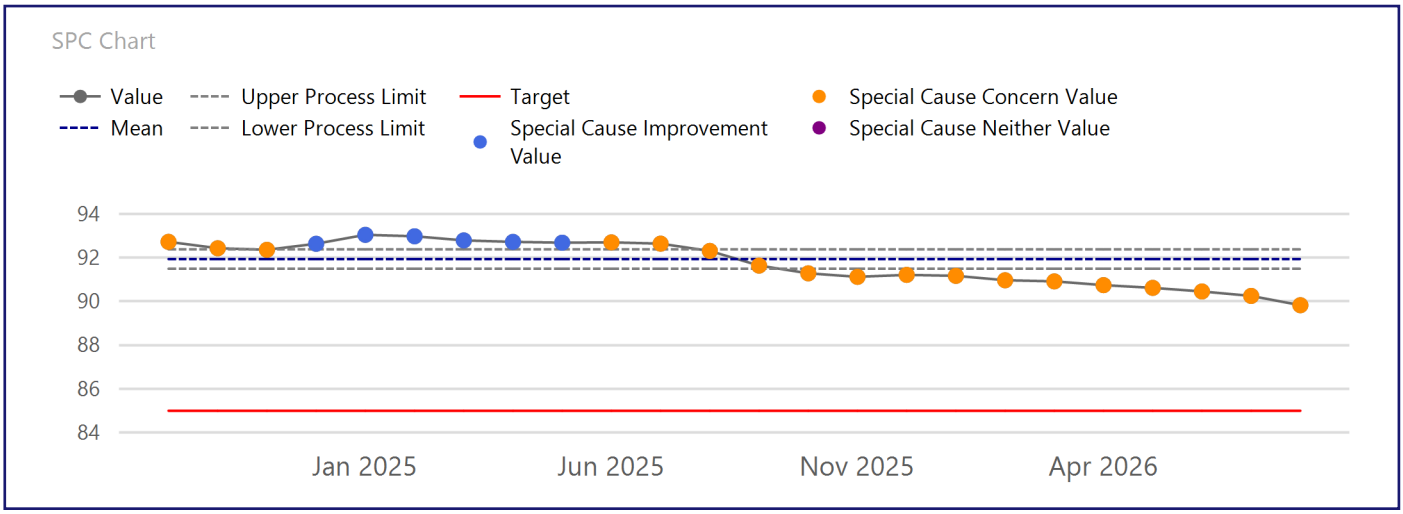
Owner: Equality & Inclusion Team

Concerns

There are minimal concerns associated with this measure. Whilst a small proportion of staff remain non-declared, the high level of completeness means this is unlikely to have a significant impact on reporting, analysis or decision-making. Continued monitoring is required to ensure performance is maintained and that any pockets of lower compliance are identified promptly.

Metric ID: 10000081 Equality Data Provision - Nationality

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	89.8281	85	P	L	Executive Director of People and Culture



Narrative

Nationality data completeness decreased from 90.46% in June 2026 to 89.83% in August 2026, a reduction of 0.63%. Although performance remains 4.83% above the organisational target of 85%, the continued reduction requires monitoring.
Accurate nationality information supports workforce planning, equality reporting and understanding of workforce demographics. Further analysis is required to establish whether the reduction is concentrated within particular services or workforce groups and whether it reflects a sustained change.

Actions and Owners

Embed equality monitoring discussions within onboarding, appraisal and routine manager conversations.

Owner: Clinical & Service Board Leads / Line Managers

Monitor compliance at service and Clinical Board level, identifying and escalating areas showing declining completion rates.

Owner: Equality & Inclusion Team/People Analytics Team

Continue targeted communications to reinforce the purpose, confidentiality and value of nationality data collection.

Owner: Equality & Inclusion Team

Following achievement of the Welsh language skills target, increase focus on improving completeness across all equality monitoring datasets.

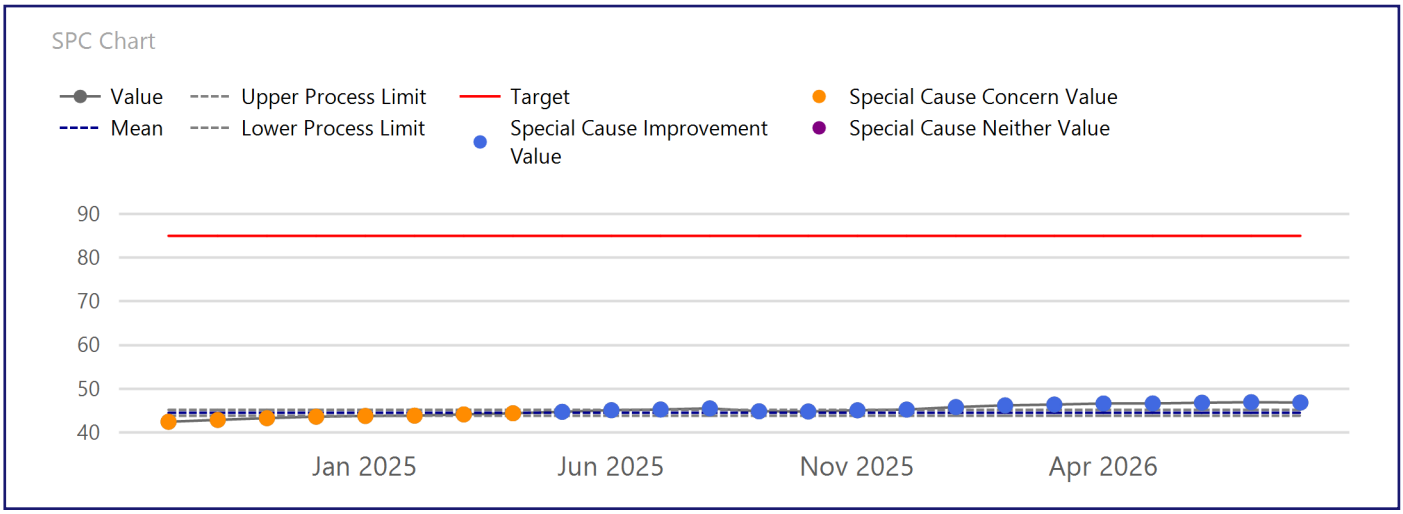
Owner: Equality & Inclusion Team

Concerns

The sustained downward trend is a concern, with approximately 10% of staff now not declaring nationality. This may indicate reduced confidence or willingness to disclose information, potentially influenced by wider external factors or a lack of understanding regarding how the data is used and protected. If the trend continues, it may reduce the reliability of workforce equality reporting and limit the organisation's understanding of workforce demographics

Metric ID: 10000082 Equality Data Provision - Country of Birth

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	46.8783	85	F	H	Executive Director of People and Culture



Narrative

Country of Birth remains the lowest-performing equality monitoring dataset, increasing marginally from 46.85% in June 2026 to 46.88% in August 2026, an improvement of only 0.03%. Performance remains 38.12% below the organisational target of 85%.
The minimal movement indicates that current processes are not generating meaningful improvement. More focused intervention is required to establish why this field remains substantially less complete than other equality monitoring information and to strengthen its collection through workforce data processes.

Actions and Owners

Embed equality monitoring discussions within onboarding, appraisal and routine manager conversations.

Owner: Clinical & Service Board Leads / Line Managers

Monitor compliance at service and Clinical Board level, identifying and escalating areas with particularly low completion rates.

Owner: Equality & Inclusion Team/People Analytics Team

Increase communications to explain the purpose and value of collecting Country of Birth data and how confidentiality is maintained.

Owner: Equality & Inclusion Team

Review current collection processes to identify opportunities to increase completion rates through ESR and other workforce data touchpoints.

Owner: Equality & Inclusion Team

Following achievement of the Welsh language skills target, increase focus on improving completeness across all equality monitoring datasets.

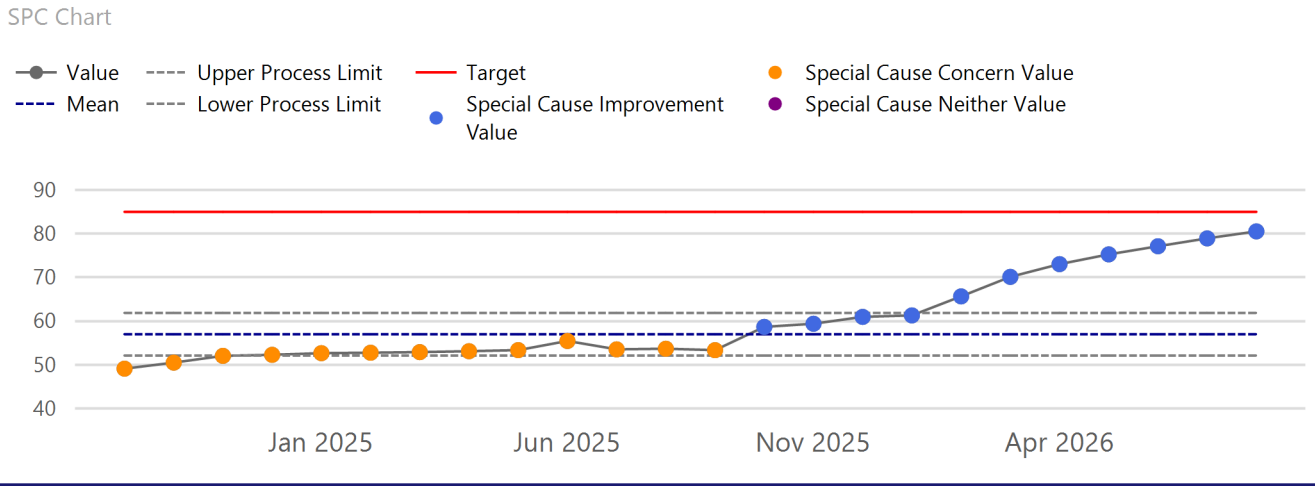
Owner: Equality & Inclusion Team

Concerns

More than half of staff have not provided Country of Birth information, significantly limiting the usefulness and reliability of the dataset for reporting and analysis. The low completion rate suggests that the data field may not be routinely discussed, prioritised or understood by staff. Without targeted intervention, improvement is likely to remain slow, reducing the value of the dataset for workforce planning and equality reporting.

Metric ID: 10000083 Identification of Welsh Skills

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	80.5332	85	F	H	Executive Director of People and Culture



Narrative

Welsh language skills registration increased from 77.48% in June 2026 to 80.53% in August 2026, an improvement of 3.05%. This represents substantial continued progress, although performance remains 4.47% below the 85% target.
Welsh language skills registration remains an organisational priority following the Welsh Language Commissioner's Standards Enforcement Investigation relating to Standard 96. The improvement indicates that targeted communications, staff engagement and enhanced organisational oversight are having a positive impact. Continued focus is required to achieve the outstanding target and ensure that recorded information remains current and reliable.
Identification of Welsh Language Skills measures the proportion of staff who have recorded a Welsh language skill level. It is distinct from Welsh Language Skills Levels 1–5, which measures the proportion reporting Welsh language capability at Level 1 or above.

Actions and Owners

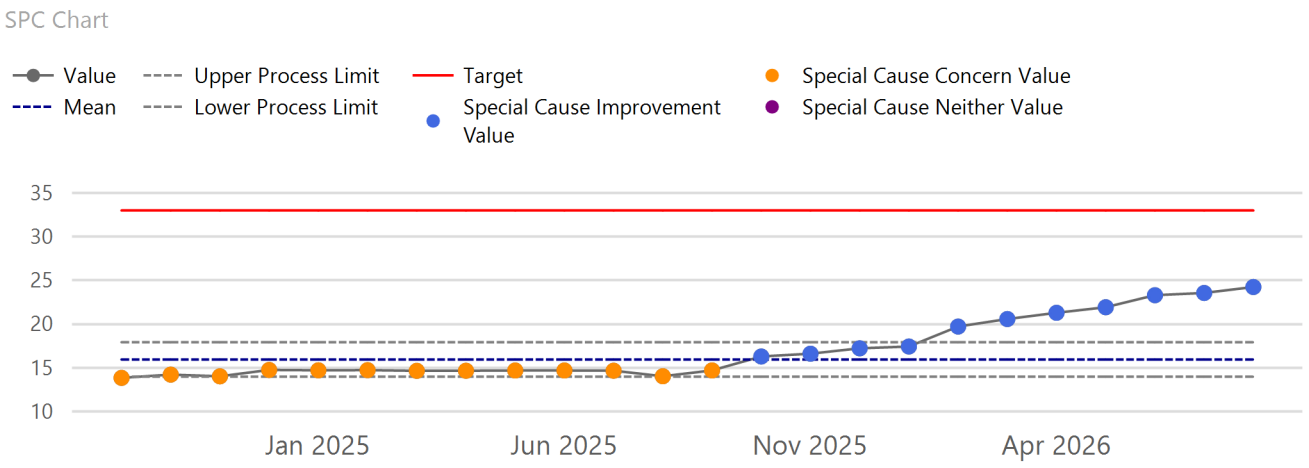
Executive Director of People & Culture

Concerns

Approximately 19.47% of staff had not recorded a Welsh language skills assessment in August 2026. Although progress remains positive, performance is still below the 85% target, and further improvement may become more challenging as activity focuses on staff who have not responded to previous engagement.
The Health Board did not achieve the 85% Welsh language skills registration target by 31 July 2026, as required by the Welsh Language Commissioner following a Standards Enforcement Investigation relating to Standard 96. The Health Board has not yet received formal correspondence from the Commissioner regarding the missed target. However, given the repeated failure to achieve the targets set through the enforcement process, there is a risk that the Commissioner may consider further regulatory action.

Metric ID: 10000084 Welsh Skills Levels 1 - 5

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	24.25	33	F	H	Executive Director of People and Culture



Narrative

The proportion of staff recording Welsh language capability at Levels 1–5 increased from 23% in June 2026 to 24.25% in August 2026, an improvement of 1.25%. Performance remains 8.75% below the organisational target of 33%.
Analysis shows that 15.44% of the workforce is recorded at Level 1, while 8.81% is recorded across Levels 2–5. Within the higher skill levels, 1.64% at Level 3, 1.77% at Level 4 and 2.46% at Level 5. Level 1 therefore accounts for the majority of currently recorded Welsh language capability.
Continued improvement in registration and capability strengthens the Health Board's ability to understand the Welsh language skills available within its workforce. However, achieving the longer-term target will require increased activity that supports staff to develop and progress their Welsh language skills via the Dysgu Cymraeg Caerdydd learning opportunities.
Welsh Language Skills Levels 1–5 measures the proportion of staff who report Welsh language capability at Level 1 or above. It is distinct from the overall registration measure.

Actions and Owners

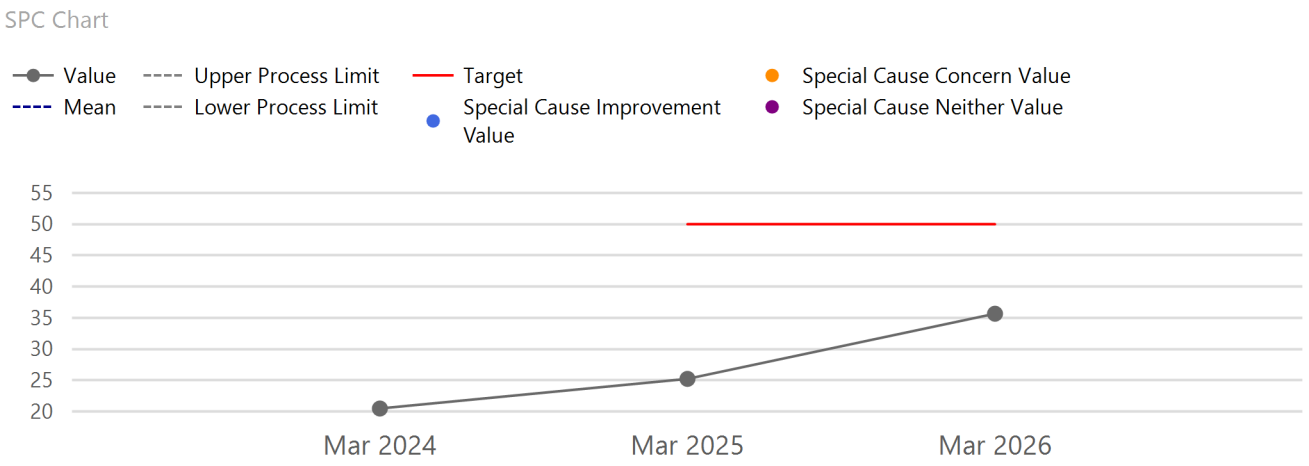
Assistant Director of OD, Culture & Education

Concerns

Performance remains substantially below the 33% target, with the majority of recorded capability at Level 1. The concern is that current Welsh language capability may not yet be sufficient to support the organisation's longer-term ambitions for bilingual service delivery, and further progress will depend on continued staff engagement and uptake of learning opportunities.

Metric ID: 10000085 Staff Survey Participation Rate

Latest Month	Value	Target	Assurance	Variation	Metric Owner
March 2026	35.6755	50	F		Executive Director of People and Culture



Narrative

The data has not changed since the previous report as the staff survey is annual. The next staff survey launches on 5th October 2026.
The Staff Survey Participation Rate was 36% in March 2026, against a target of 50%. As this is an annual measure reported following the staff survey in Quarter 4, SPC interpretation is limited due to the small number of data points available. The latest result demonstrates an improvement compared to the previous year, indicating increased staff participation in providing feedback. Whilst the direction of travel is positive, participation remains below the organisational target and further improvement is required to ensure staff views are fully representative of the workforce.

Actions and Owners

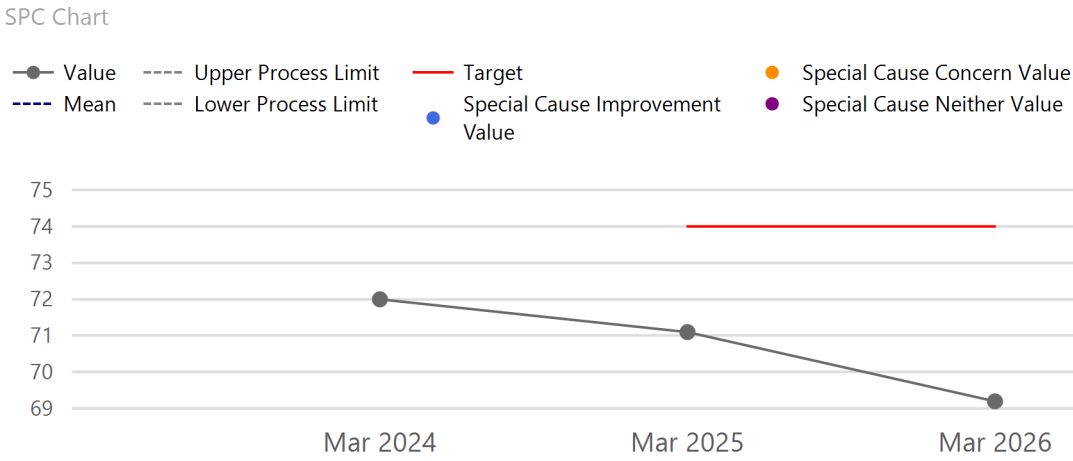
- Clinical Boards are working with staff to develop and deliver co-produced local actions that demonstrate how staff feedback is being listened to and acted upon.
- Targeted engagement activity will continue to promote participation and increase awareness of the value and impact of staff survey feedback.
- Progress against staff survey actions and improvement plans is monitored through Executive Performance Reviews at Clinical Board level, providing oversight and accountability for delivery.
- Learning from areas with higher participation rates will be used to inform future engagement and survey campaigns.

Concerns

Participation remains below the organisational target of 50%.
Lower response rates may limit confidence that survey findings fully reflect the experiences and views of the wider workforce.
Some staff groups or services may be under-represented within survey responses, reducing the breadth of insight available to inform improvement activity.
As the measure is reported annually, opportunities to evaluate the impact of interventions are limited between survey cycles.

Metric ID: 10000086 Engagement Score

Latest Month	Value	Target	Assurance	Variation	Metric Owner
March 2026	69.2	74	F		Executive Director of People and Culture



Narrative

The data has not changed since the previous report as the staff survey is annual. The next staff survey launches on 5th October 2026.

The Engagement Score was 69% in March 2026, compared with a target of 74%. As this metric is derived from the annual staff survey and reported in Quarter 4, there are limited data points available and SPC interpretation should therefore be applied with caution. The latest result indicates a reduction from the previous year and remains below the organisational target. Whilst the chart suggests a downward movement in engagement, the annual nature of the measure means that trends should be considered alongside supporting workforce indicators and staff feedback to fully understand the underlying drivers.

Actions and Owners

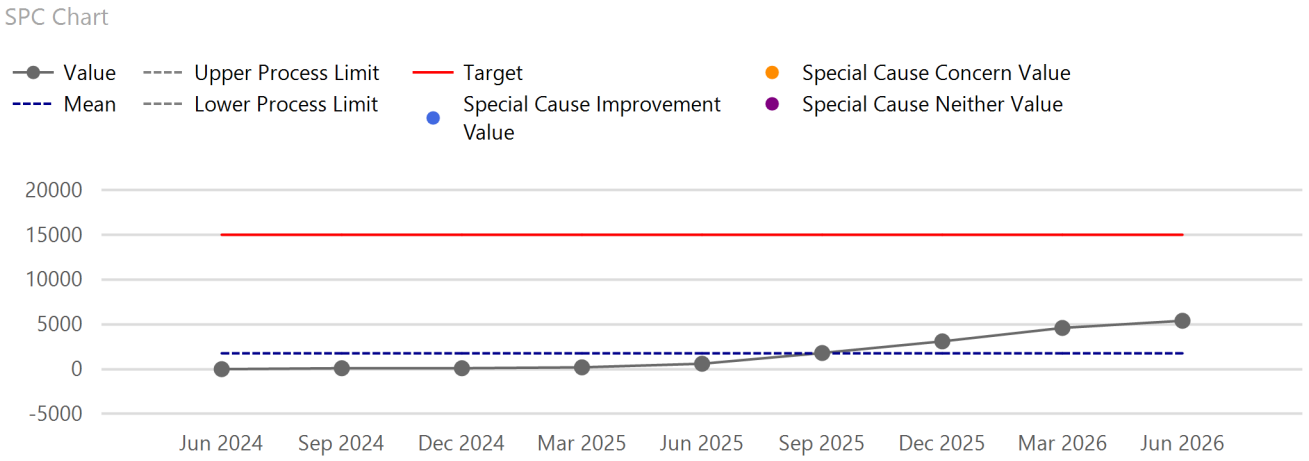
Clinical Boards are developing and delivering co-produced local action plans with staff, focusing on the key priorities identified through staff survey feedback.
Progress against staff survey actions and associated improvement plans is monitored through Executive Performance Reviews at Clinical Board level.
Ongoing focus will be placed on embedding improvements in areas such as staff experience, engagement and wellbeing, while evaluating impact through future staff survey results and supporting workforce indicators.

Concerns

The Engagement Score remains below the organisational target of 74%, with a current position of 69%.
The latest survey result reflects a deterioration compared to the previous reporting period.
Lower levels of staff engagement may adversely impact staff wellbeing, retention, productivity and organisational culture.
As the metric is only reported annually, there is a delayed feedback loop which can make it difficult to assess the immediate impact of improvement initiatives.
Further analysis of staff survey themes and local intelligence gathering is underway at a local level to understand the factors influencing engagement levels.

Metric ID: 10000087 Workforce Planning Training Completion

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	5400	15000			Executive Director of People and Culture



Narrative

Workforce Planning Training attendance data is received from HEIW on a quarterly basis. There is no update for the IPR this month.

The completion of the HEIW Introduction to Strategic Workforce Planning programme continues to support the Health Board's strategic objective of strengthening workforce planning capability and moving from annual resource-based workforce planning towards operational and integrated workforce planning aligned to service and financial plans. The organisational target is for 150 managers to complete the training by 31 March 2027. By the end of Q1 2026/27, 36% of this target had been achieved, demonstrating ongoing engagement and gradual uptake since the programme was introduced in 2024.

Actions and Owners

Whilst progress is being made, only 36% of the 150-manager target had been achieved by the end of Q1 2026/27. Continued growth in completions will be required to achieve the March 2027 ambition.

The suitability of the current programme is being reviewed by the Strategic Workforce Planning Lead, Senior People & Culture Business Partners and the Head of Education. Any changes to the training offer could influence future completion patterns and should be considered when interpreting subsequent results.

Concerns

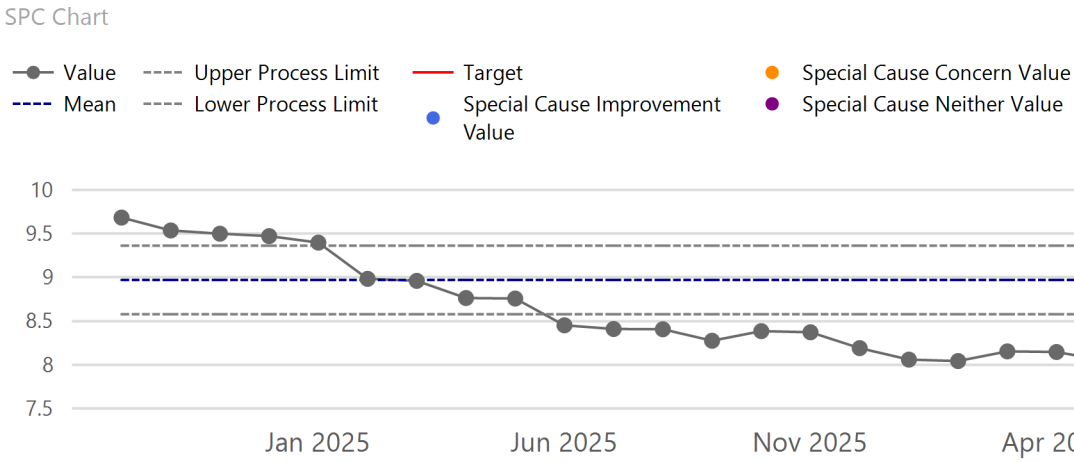
From an SPC perspective, the current dataset should be interpreted with caution. The available information suggests continued improvement in cumulative training completions; however, there are insufficient data points to establish a reliable baseline, calculate control limits or distinguish between common cause and special cause variation. Consequently, the chart should currently be viewed as a developing measure rather than a mature SPC process.

The programme is promoted and encouraged but is not mandatory. This creates a risk that completion rates may plateau, particularly during periods of operational pressure.

Capacity and prioritisation of operational managers are a continuing challenge. Competing service demands may limit managers' ability to undertake training and could affect future completion trajectories.

Metric ID: 10000088 Turnover - All Staff

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	7.7026				Executive Director of People and Culture



Narrative

The annualised turnover rate was 7.7% in August 2026, remaining within the Health Board's target range of 7% to 9%. Performance has shown a sustained and positive reduction over the last 12 months, indicating improved workforce stability and supporting organisational efforts to retain staff. The continued downward trend provides assurance that retention initiatives and broader workforce interventions are having a positive impact. Maintaining turnover within the target range will remain important in supporting service continuity, reducing recruitment pressures and retaining organisational knowledge and experience.

Actions and Owners

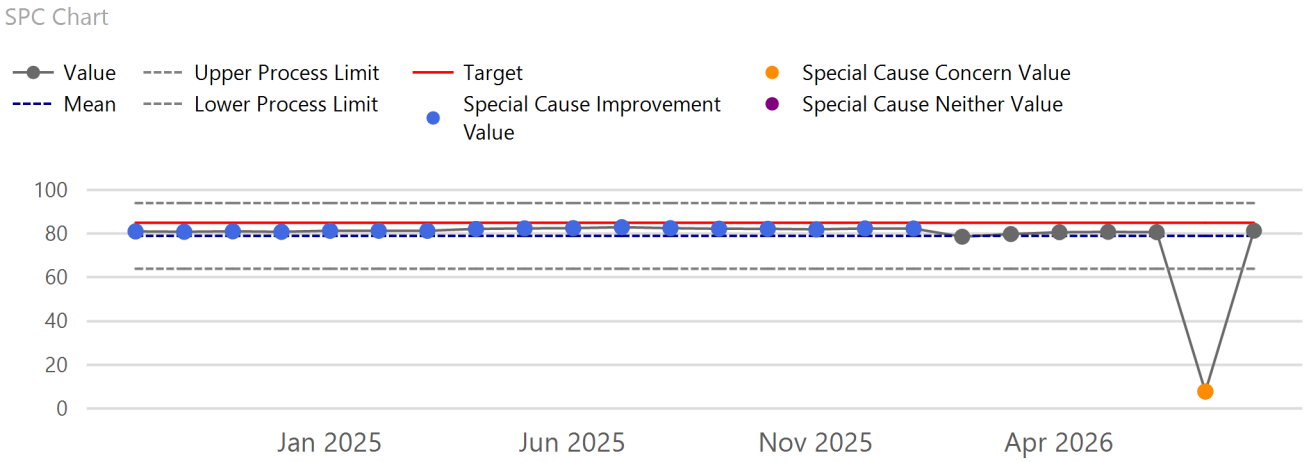
Continue to monitor turnover trends at Health Board, Clinical Board and Directorate level, identifying hotspots and emerging risks.
Utilise exit interview and turnover data to understand key drivers of staff leaving and inform targeted retention actions.
Support implementation of local retention initiatives, particularly in hard-to-recruit and high-turnover areas.
Continue promoting staff wellbeing, career development, leadership development and flexible working opportunities to support retention.
Review turnover performance regularly through workforce governance arrangements and ensure targeted action plans are in place where required.

Concerns

Although turnover remains within the target range, continued monitoring is required to ensure the downward trend is sustained. Workforce pressures, labour market competition and organisational change may impact future retention levels if not actively managed. There is also a need to understand and address any areas with higher levels of turnover to ensure improvement is consistent across all staff groups and service areas.
Failure to maintain current performance could increase recruitment costs, place additional pressure on teams and affect service delivery.

Metric ID: 10000089 Statutory and Mandatory Training

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	81.3796	85			Executive Director of People and Culture



Narrative

Statutory and Mandatory Training compliance was 81% in August 2026, an improvement in performance but remaining below the Health Board target of 85%. Whilst the gap to target has narrowed, the current level of compliance does not yet provide full assurance that all staff have completed the mandatory learning required for their role. Improvement activity continues through enhanced local oversight, regular performance monitoring and targeted follow-up of overdue training. Continued focus is required to sustain the positive trajectory and achieve the required compliance standard across all staff groups and service areas.

Actions and Owners

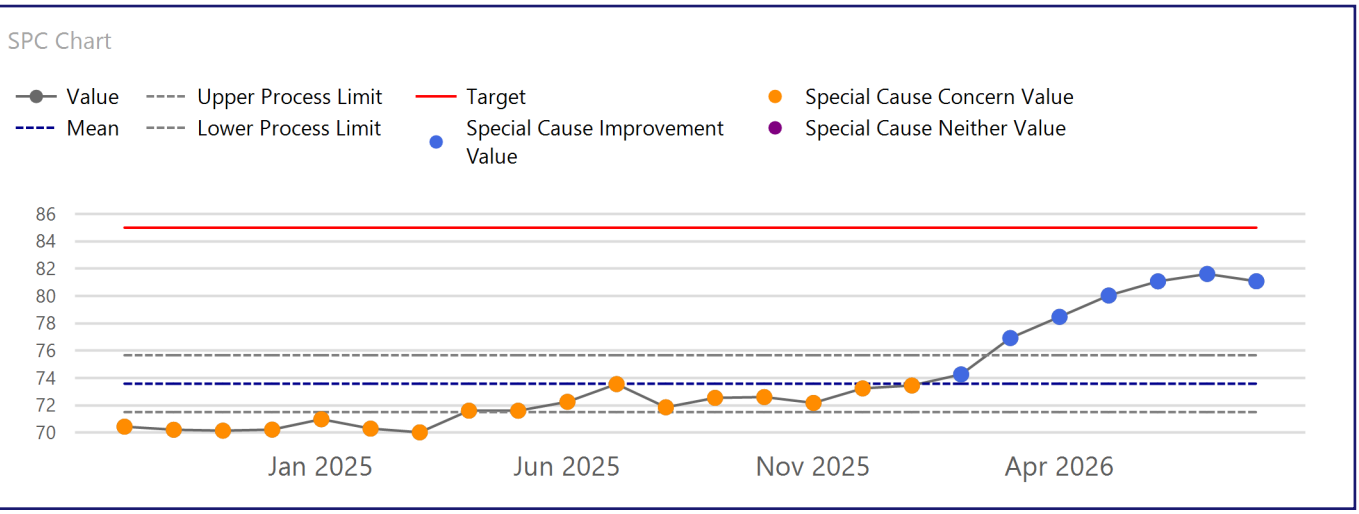
Clinical Boards and Directorates to continue delivery of local recovery plans focused on staff with overdue mandatory training.
Line managers to undertake regular reviews of compliance reports and ensure outstanding training is completed within agreed timescales.
Learning and Development teams to provide targeted support and escalation for areas significantly below target.
Compliance performance to be routinely reviewed through governance, performance and accountability arrangements.
Executive Directors and Clinical Board leadership teams to maintain oversight of compliance trajectories and hold managers accountable for delivery of improvement plans.

Concerns

Although performance has improved, compliance remains 4% below target, limiting assurance regarding workforce compliance with statutory and mandatory training requirements. Variation between Clinical Boards, Directorates and staff groups continues to impact overall performance, indicating inconsistent levels of completion and local management oversight. Failure to achieve the target may result in increased organisational risk relating to patient safety, workforce preparedness, governance and regulatory compliance. Sustained improvement will be required to ensure compliance is embedded and maintained across the organisation.

Metric ID: 10000090 Fire Learning

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	81.0778	85	F	H	Executive Director of People and Culture



Narrative

Fire Safety training compliance improved to 81% in August 2026, representing continued progress towards the Health Board target of 85%. Whilst the direction of travel is positive, compliance remains below the required standard and therefore does not yet provide full assurance that all staff have completed the mandated training. Improvement has been supported through targeted monitoring, local management action and increased focus on mandatory training completion. Sustained effort is required to maintain momentum and close the remaining compliance gap, particularly in services with lower levels of performance.

Actions and Owners

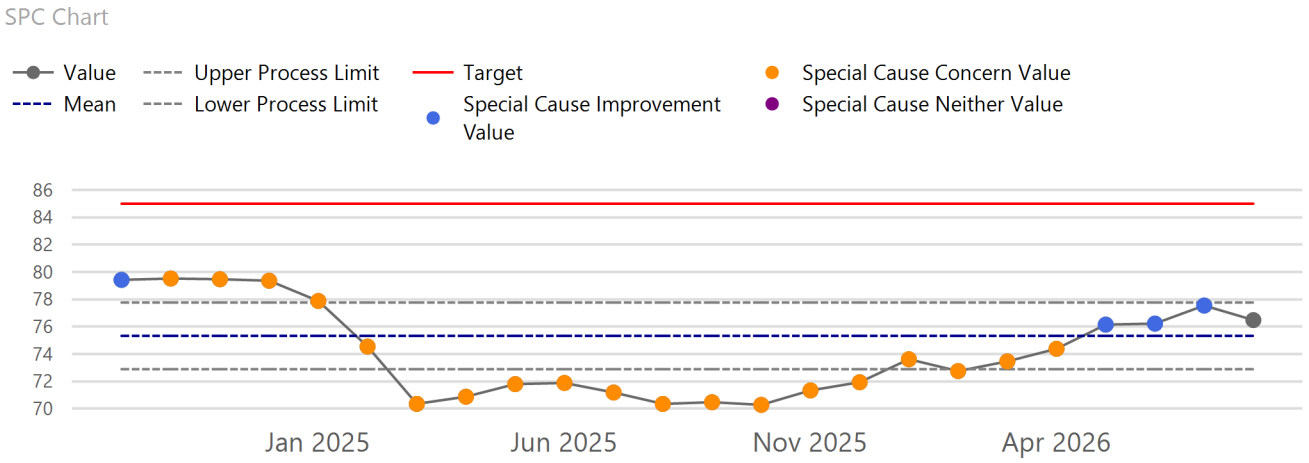
Clinical Boards and Directorates to continue targeted improvement plans for areas below target.
Line managers to actively monitor staff compliance and ensure outstanding Fire Safety training is completed within agreed timescales.
Learning and Development teams to provide regular compliance reports and support targeted interventions in low-performing areas.
Compliance performance to be reviewed through established governance and performance management arrangements, with escalation where progress is insufficient.
Executive Directors and Clinical Board leadership teams to maintain oversight of compliance trajectories and hold managers accountable for delivery of improvement plans.

Concerns

Although compliance has improved, performance remains 4% below target, limiting assurance that all staff have completed essential Fire Safety training requirements. Variation in compliance between services indicates inconsistent levels of completion and local oversight. Failure to achieve and sustain the required compliance level may increase organisational risk in relation to staff safety, emergency preparedness and regulatory requirements. Continued improvement is required to ensure compliance is embedded and maintained across all areas.

Metric ID: 10000091 Values-Based Appraisal

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	76.4815	85	F		Executive Director of People and Culture



Narrative

VBA compliance was 76% in August 2026, remaining below the Health Board target of 85%. Although compliance continues to be supported through regular monitoring, reporting and local management action, the current position does not provide the level of assurance required for statutory and mandatory training compliance. Performance indicates that a significant proportion of staff have outstanding requirements, with variation in compliance across services and staff groups. Sustained improvement is required to reduce the gap to target and strengthen assurance regarding workforce safety, governance and regulatory compliance.

Actions and Owners

Targeted recovery actions are in place to improve compliance and close the gap to the 85% target. Focus will continue on strengthening managerial accountability, improving local oversight and ensuring timely completion of outstanding training requirements.

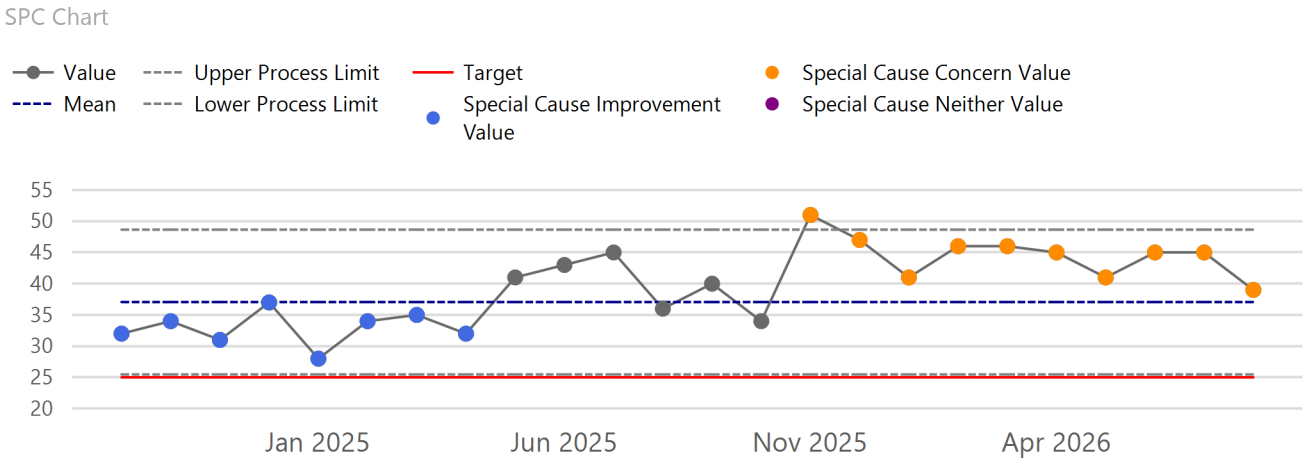
Clinical Boards and Directorates to review compliance performance monthly and implement targeted recovery actions in areas below trajectory.
Line managers to undertake active follow-up with staff who have overdue mandatory training and ensure completion plans are in place.
Learning and Development teams to provide targeted support, reporting and escalation for persistently low-performing areas.
Compliance performance to continue to be monitored through established governance arrangements and escalated where improvement is not being achieved.
Executive Directors and Clinical Board leadership teams to maintain oversight of compliance trajectories and delivery of recovery plans.

Concerns

Compliance remains 9 percentage points below target, resulting in limited assurance that all staff have completed the required mandatory training components. Variation in performance across Clinical Boards and service areas suggests inconsistent levels of local oversight and engagement. Failure to improve compliance presents risks relating to workforce readiness, patient safety, regulatory compliance and organisational assurance. Without accelerated improvement and strengthened accountability, achievement of the target within the required timeframe may be challenging.xx

Metric ID: 10000092 Employee Relations Activity - Disciplinary

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	39	25	F	H	Executive Director of People and Culture



Narrative

Employee Relations Activity relating to disciplinary cases reported a value of 39 in August 2026, above the organisational target of 25. The XmR chart demonstrates a sustained increase in disciplinary case activity when compared with the historic process mean. The latest reported performance suggests that disciplinary activity remains at a higher level than anticipated and may indicate underlying workforce, management, conduct or organisational culture challenges requiring further investigation.

Actions and Owners

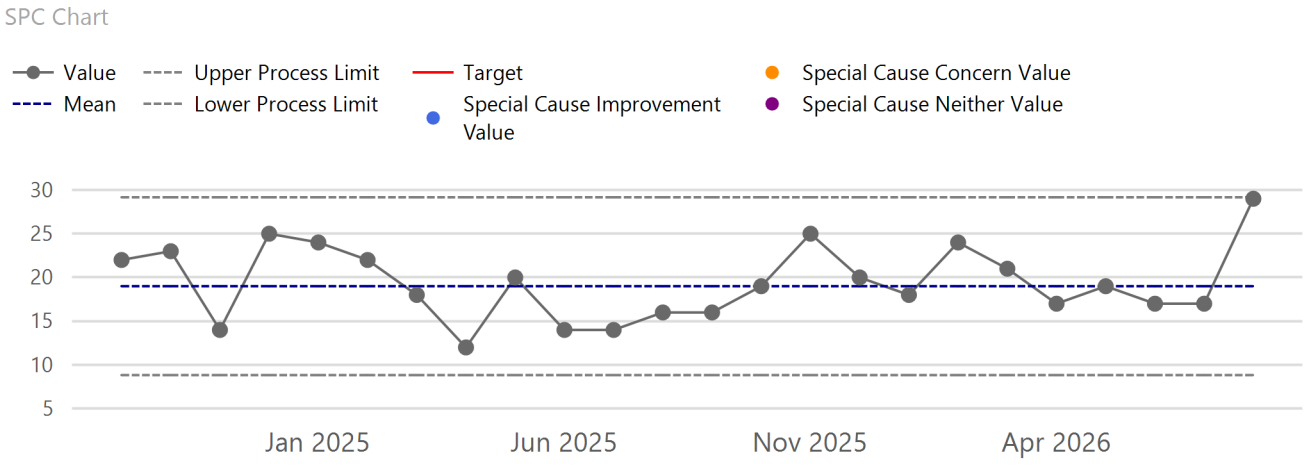
Undertake thematic analysis of all disciplinary cases to identify common causes, hotspots and emerging trends across Clinical Boards and Directorates.
Review open disciplinary cases to ensure progress is being managed in line with policy timescales and identify opportunities for earlier resolution where appropriate.
Head of People Services

Concerns

Disciplinary case activity remains above the target level, with 39 live cases reported against a target of 25. Sustained levels of disciplinary activity may place additional pressure on management capacity, Employee Relations resources and organisational wellbeing, whilst also indicating potential workforce culture, conduct or management practice issues that require intervention.

Metric ID: 10000093 Employee Relations Activity - Respect and Resolution

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	29				Executive Director of People and Culture



Narrative

Formal Respect and Resolution activity recorded 29 cases in August 2026. Formal case numbers should be interpreted alongside informal activity and broader organisational intelligence.

Actions and Owners

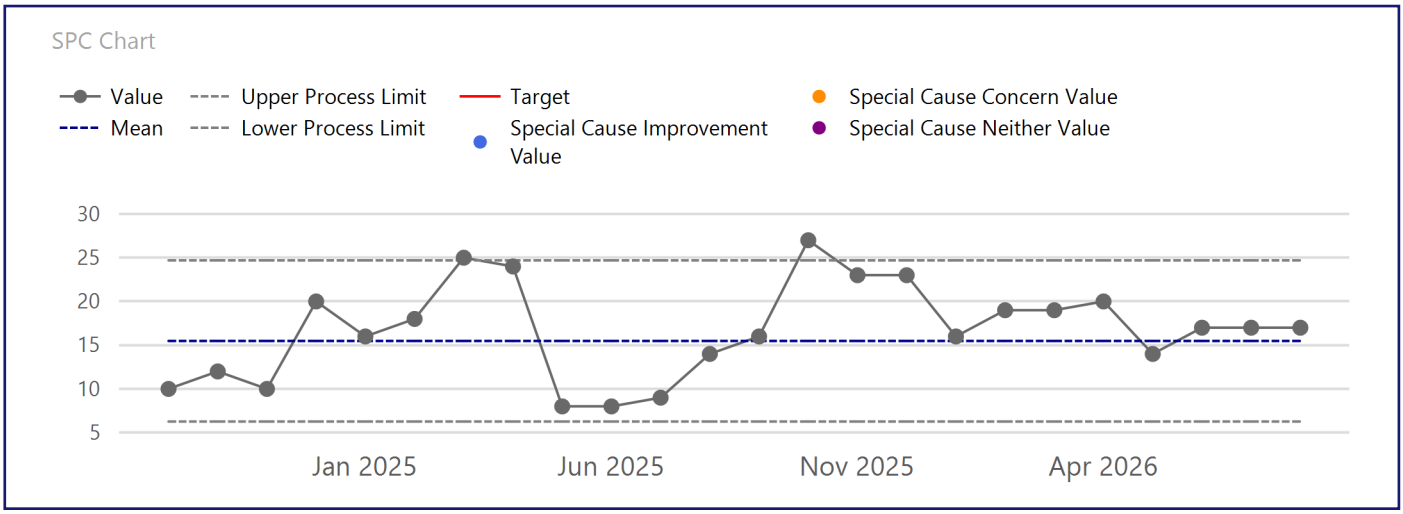
Undertake a thematic review of formal and informal Respect and Resolution cases, covering behaviours, relationship breakdown, communication, discrimination or harassment, management decisions and dissatisfaction with other processes.
Analyse activity by Clinical Board and Directorate to identify hotspots, recurring themes and areas where formal case volumes are persistently higher.

Concerns

The sustained level of Respect and Resolution activity indicates that workplace conflicts and concerns continue to require formal intervention across the organisation. Whilst the SPC chart does not currently indicate special cause variation, the ongoing caseload may reflect underlying challenges relating to staff behaviours, communication, working relationships, management practice and perceptions of fairness. Without greater understanding of the themes and drivers behind both formal and informal cases, opportunities for preventative action and early intervention may be missed.

Metric ID: 10000094 Employee Relations Activity - Appeals

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	17				Executive Director of People and Culture



Narrative

The latest value is 17 appeals for August 2026. The chart identifies common-cause variation, indicating that the movement is currently consistent with the established performance of the system rather than being attributable to a single exceptional event or special cause. No target assurance assessment is currently shown. The August position should remain under review to determine whether appeals are becoming sustained at a higher level or whether the latest result remains within expected variation.

Actions and Owners

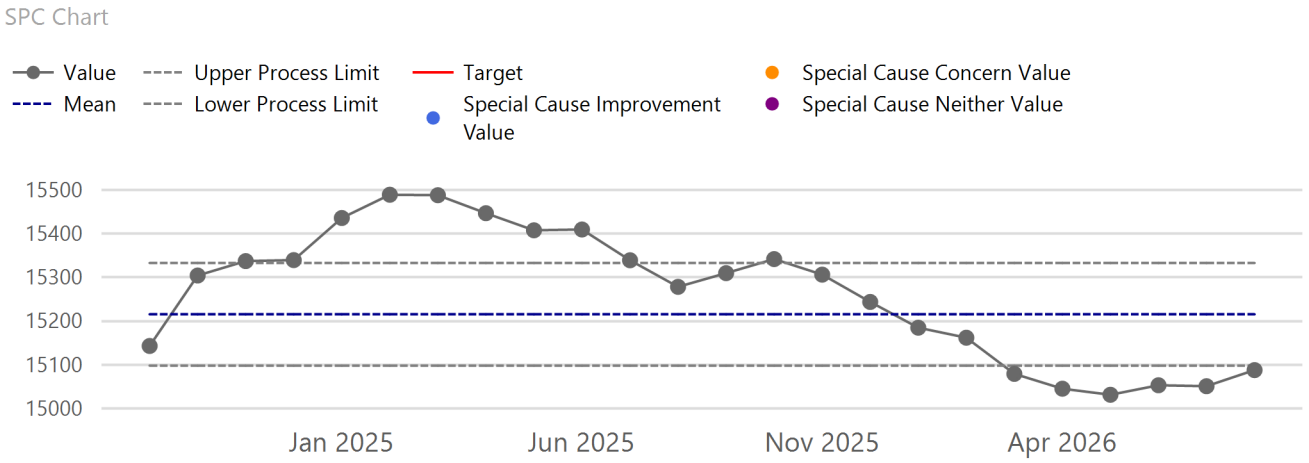
Complete a case-level review of the current appeals, covering case type, Clinical Board, grounds of appeal, procedural stage, timescale and outcome.

Concerns

The principal concern is the current volume of 17 appeals and the absence of target assurance, rather than evidence of statistically significant deterioration. Common-cause variation suggests that, if a reduction is required, improvement is likely to depend on changes to the underlying employee relations system rather than a response to individual monthly movements.

Metric ID: 10000095 WTE Staff in Post

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	15088.16				Executive Director of People and Culture



Narrative

WTE Staff in Post was 15,088.2 in August 2026. The SPC chart identifies the position as Neither (Low) variation, indicating that staffing levels remain stable and are fluctuating within normal expected limits rather than demonstrating a significant upward or downward trend. There is currently no evidence of special cause variation, suggesting that workforce numbers are broadly consistent with the established baseline position.

Actions and Owners

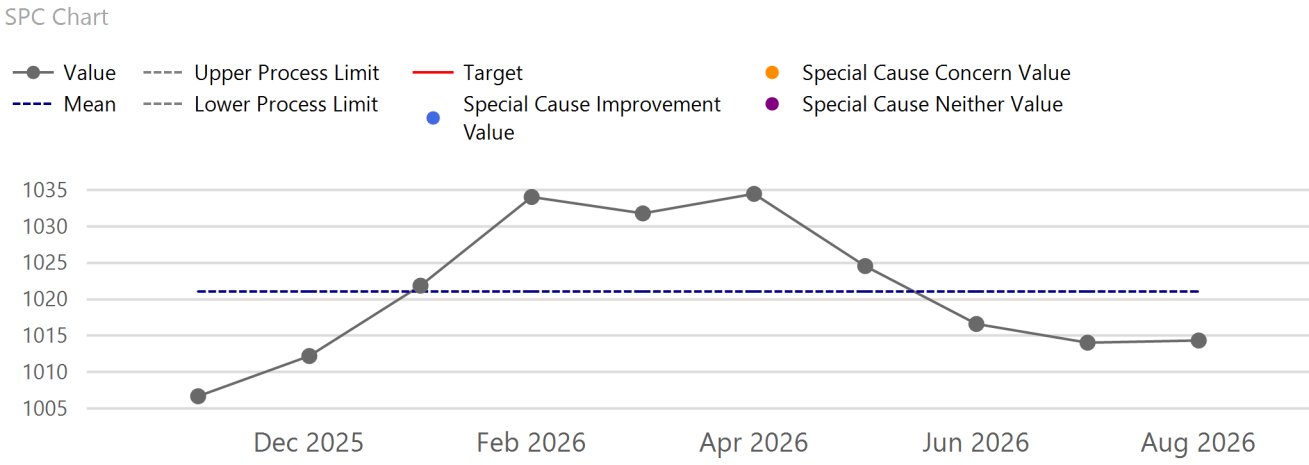
* Continue weekly and monthly monitoring of WTE Staff in Post through the turnaround meetings and EPRs.
* Review workforce movements, including recruitment, turnover, retirements and vacancy controls, to ensure staffing levels remain aligned to organisational plans.
* Support Clinical Boards, CEF and Corporate Directorates to manage establishment levels within agreed workforce and financial envelopes. * Escalate any emerging special cause variation or significant workforce growth through established performance and accountability arrangements.

Concerns

* Workforce levels remain relatively static, with no sustained reduction or increase identified through SPC analysis.
* Continued stability in staffing numbers may present challenges where organisational objectives require active workforce growth restraint, workforce reduction, or redistribution of resources to priority services.
* Ongoing monitoring is required to ensure that recruitment activity, turnover rates, and vacancy management remain aligned with financial recovery and workforce planning objectives.

Metric ID: 10000096 GMS Contractor WTE Staff in Post

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	1014.35				Executive Director of People and Culture



Narrative

GMS Contractor WTE is reported to Board as a requirement of the Ministerial Advisory Group (MAG) Primary Care performance framework. As this is a monitoring measure, no performance target has been established. Reporting provides visibility of workforce capacity within commissioned optometry services and supports oversight of primary care workforce sustainability, service access and workforce planning. Trends will continue to be monitored to identify changes in workforce capacity and to inform planning and commissioning discussions where required.

Actions and Owners

The Health Board will continue to monitor Optometry Contractor WTE through routine reporting arrangements and use the information to support workforce planning and service sustainability discussions.

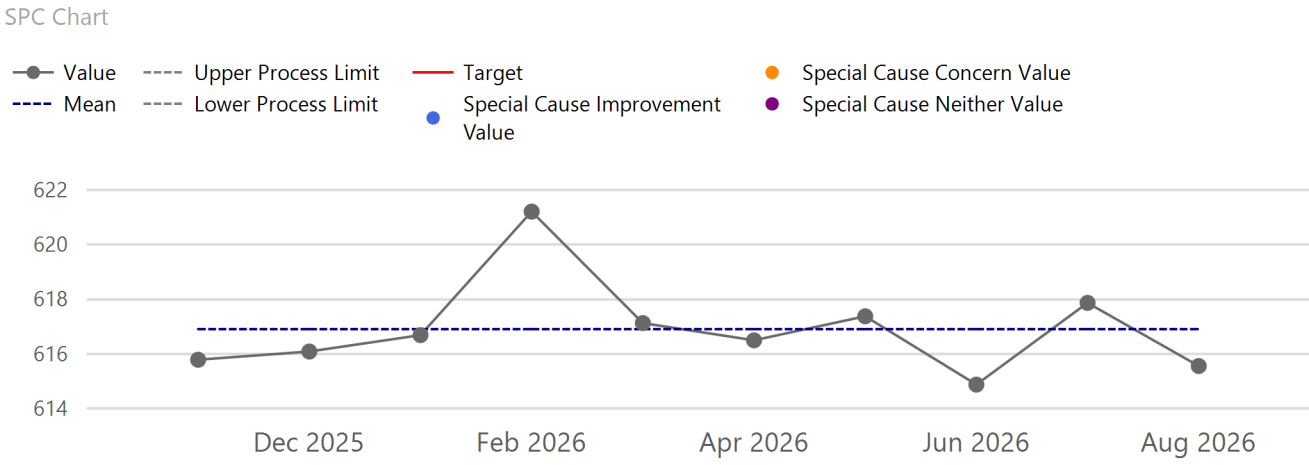
Continue to report Optometry Contractor WTE to Board in line with MAG reporting requirements.
Monitor workforce trends, including increases or reductions in contractor capacity, to identify emerging risks.
Work with primary care contractors and relevant stakeholders to understand workforce challenges and opportunities.
Use workforce data to inform primary care service planning, commissioning and sustainability discussions.
Escalate any significant workforce capacity concerns through appropriate governance arrangements.

Concerns

Whilst no target has been set for this measure, maintaining appropriate workforce capacity across commissioned optometry services remains important to support service delivery and access for patients. Changes in contractor WTE, recruitment challenges, retirements or reductions in available clinical sessions may impact capacity and service resilience. Ongoing monitoring is therefore required to identify emerging workforce risks and inform mitigating actions where necessary.

Metric ID: 10000097 Dental Contractor WTE Staff in Post

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	615.56				Executive Director of People and Culture



Narrative

Dental Contractor WTE is reported to Board as a requirement of the Ministerial Advisory Group (MAG) Primary Care performance framework. As this is a monitoring measure, no performance target has been established. Reporting provides visibility of workforce capacity within commissioned optometry services and supports oversight of primary care workforce sustainability, service access and workforce planning. Trends will continue to be monitored to identify changes in workforce capacity and to inform planning and commissioning discussions where required.

Actions and Owners

The Health Board will continue to monitor Optometry Contractor WTE through routine reporting arrangements and use the information to support workforce planning and service sustainability discussions.

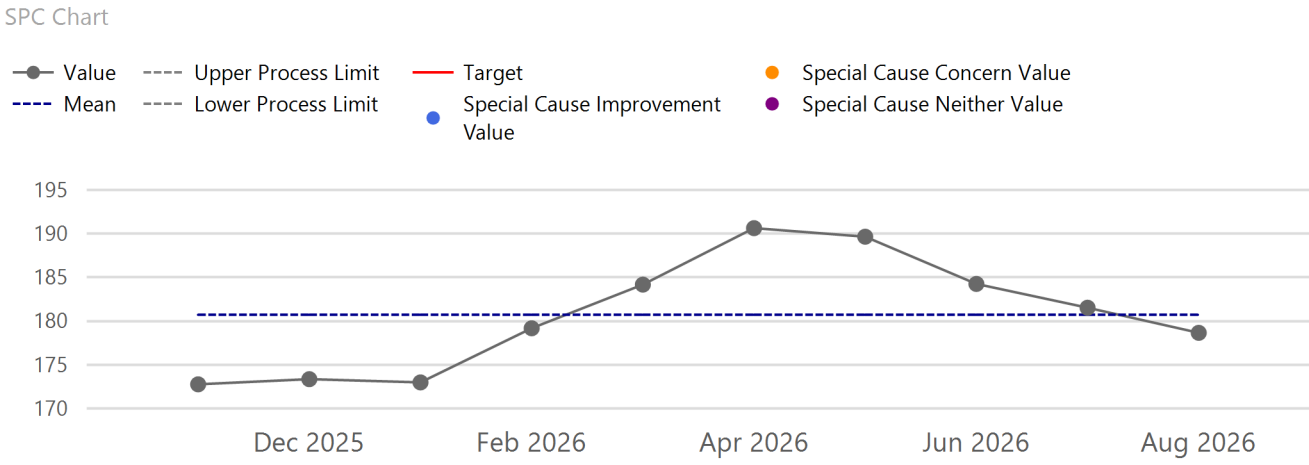
Continue to report Optometry Contractor WTE to Board in line with MAG reporting requirements.
Monitor workforce trends, including increases or reductions in contractor capacity, to identify emerging risks.
Work with primary care contractors and relevant stakeholders to understand workforce challenges and opportunities.
Use workforce data to inform primary care service planning, commissioning and sustainability discussions.
Escalate any significant workforce capacity concerns through appropriate governance arrangements.

Concerns

Whilst no target has been set for this measure, maintaining appropriate workforce capacity across commissioned optometry services remains important to support service delivery and access for patients. Changes in contractor WTE, recruitment challenges, retirements or reductions in available clinical sessions may impact capacity and service resilience. Ongoing monitoring is therefore required to identify emerging workforce risks and inform mitigating actions where necessary.

Metric ID: 10000098 Optometry Contractor WTE Staff in Post

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	178.67				Executive Director of People and Culture



Narrative

Optometry Contractor WTE is reported to Board as a requirement of the Ministerial Advisory Group (MAG) Primary Care performance framework. As this is a monitoring measure, no performance target has been established. Reporting provides visibility of workforce capacity within commissioned optometry services and supports oversight of primary care workforce sustainability, service access and workforce planning. Trends will continue to be monitored to identify changes in workforce capacity and to inform planning and commissioning discussions where required.

Actions and Owners

The Health Board will continue to monitor Optometry Contractor WTE through routine reporting arrangements and use the information to support workforce planning and service sustainability discussions.

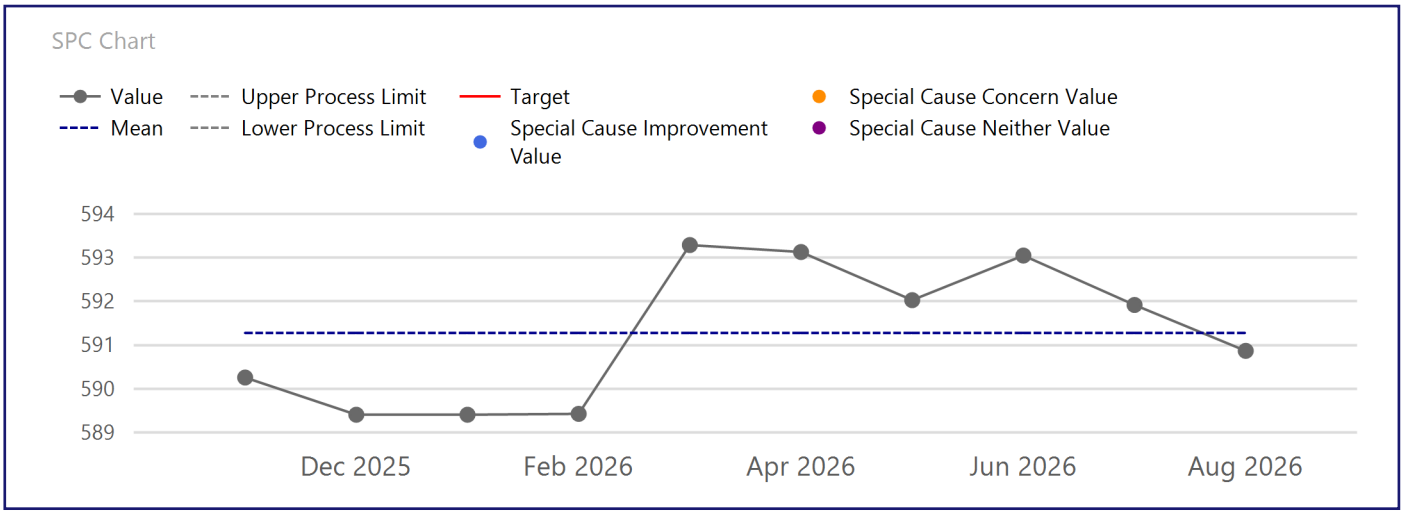
Continue to report Optometry Contractor WTE to Board in line with MAG reporting requirements.
Monitor workforce trends, including increases or reductions in contractor capacity, to identify emerging risks.
Work with primary care contractors and relevant stakeholders to understand workforce challenges and opportunities.
Use workforce data to inform primary care service planning, commissioning and sustainability discussions.
Escalate any significant workforce capacity concerns through appropriate governance arrangements.

Concerns

Whilst no target has been set for this measure, maintaining appropriate workforce capacity across commissioned optometry services remains important to support service delivery and access for patients. Changes in contractor WTE, recruitment challenges, retirements or reductions in available clinical sessions may impact capacity and service resilience. Ongoing monitoring is therefore required to identify emerging workforce risks and inform mitigating actions where necessary.

Metric ID: 10000099 Community Pharmacy Contractor WTE Staff in Post

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	590.87				Executive Director of People and Culture



Narrative

Community Pharmacy Contractor WTE is reported to Board as a requirement of the Ministerial Advisory Group (MAG) Primary Care performance framework. As this is a monitoring measure, no performance target has been established. Reporting provides visibility of workforce capacity within commissioned optometry services and supports oversight of primary care workforce sustainability, service access and workforce planning. Trends will continue to be monitored to identify changes in workforce capacity and to inform planning and commissioning discussions where required.

Actions and Owners

The Health Board will continue to monitor Optometry Contractor WTE through routine reporting arrangements and use the information to support workforce planning and service sustainability discussions.

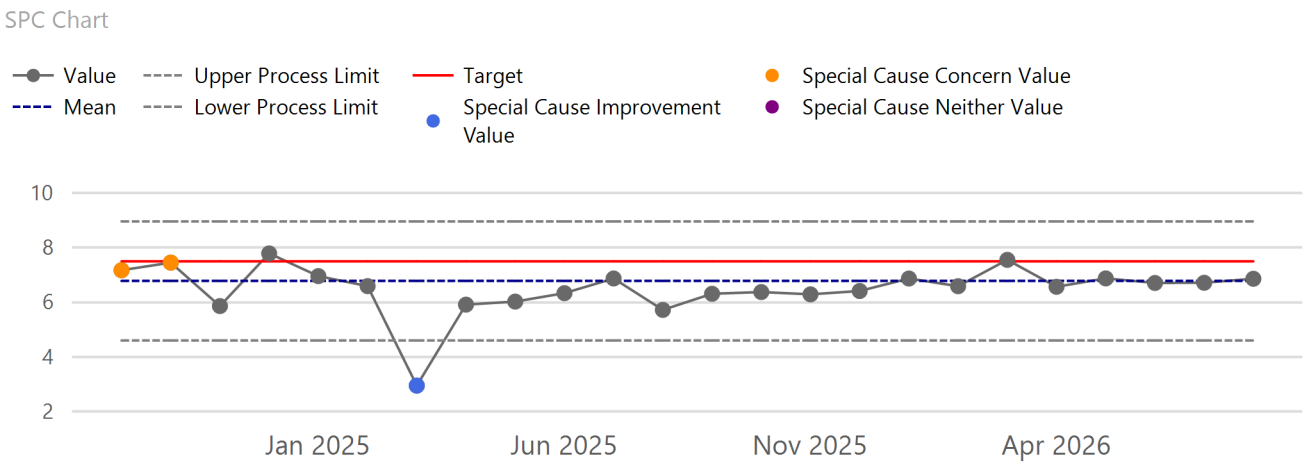
Continue to report Optometry Contractor WTE to Board in line with MAG reporting requirements.
Monitor workforce trends, including increases or reductions in contractor capacity, to identify emerging risks.
Work with primary care contractors and relevant stakeholders to understand workforce challenges and opportunities.
Use workforce data to inform primary care service planning, commissioning and sustainability discussions.
Escalate any significant workforce capacity concerns through appropriate governance arrangements.

Concerns

Whilst no target has been set for this measure, maintaining appropriate workforce capacity across commissioned optometry services remains important to support service delivery and access for patients. Changes in contractor WTE, recruitment challenges, retirements or reductions in available clinical sessions may impact capacity and service resilience. Ongoing monitoring is therefore required to identify emerging workforce risks and inform mitigating actions where necessary.

Metric ID: 10000100 Percentage of Pay Spend Attributed to Variable Pay

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	6.8619	7.5			Executive Director of People and Culture



Narrative

Variable pay (Bank) continues to be monitored against the target of achieving a greater than 10% reduction in 26/27 based on the outturn from 25/26 expenditure. The SPC chart demonstrates a stable pattern of variation with no sustained special cause improvement evident at this stage.

Actions and Owners

Require each Clinical Board to develop and deliver a trajectory to achieve its share of the £4m bank expenditure reduction target, supported by measurable milestones and monthly monitoring.
Undertake detailed analysis of the principal drivers of bank expenditure, including vacancies, sickness absence, enhanced observation requirements and rostering inefficiencies, with targeted action plans for high-spend areas.
Strengthen scrutiny and challenge through turnaround meetings, Executive Performance reviews where bank expenditure is not reducing in line with planned savings trajectories.
Optimise e-rostering, job planning and deployment practices to maximise utilisation of substantive staff before bank shifts are requested.

Concerns

Performance is not currently delivering the level of reduction required to support the Health Board's financial recovery expectations and associated savings programme.

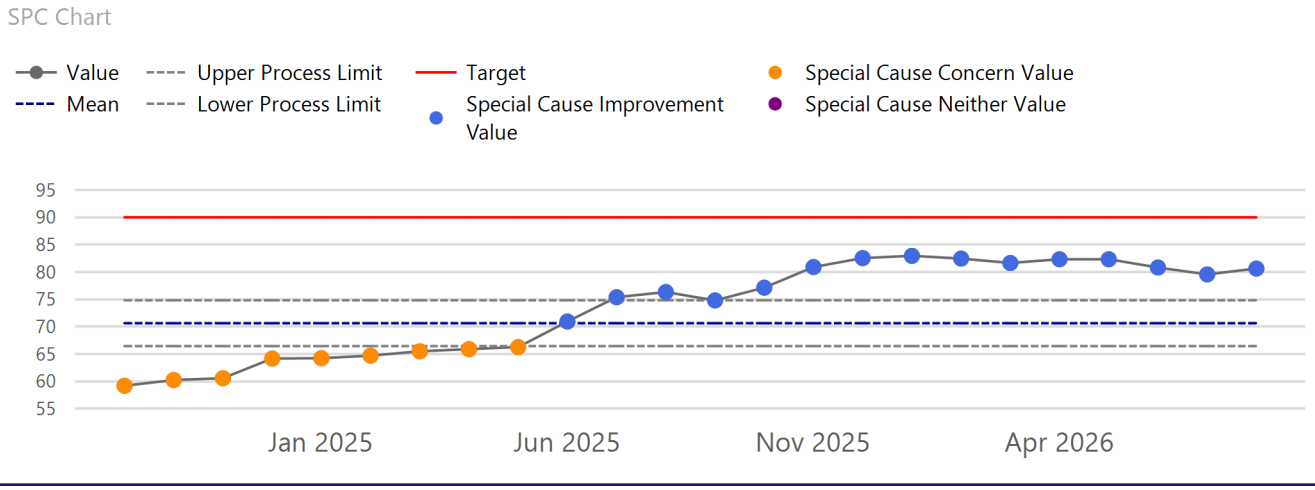
The 2026/27 savings plan includes a requirement to deliver approx. £4 million reduction in bank expenditure, and current expenditure trends suggest there is a risk that this target may not be fully achieved without additional intervention.

The SPC chart shows common cause variation, indicating that expenditure has stabilised at around the current level. Whilst this demonstrates control, it also suggests that existing measures are not generating the sustained downward shift required to deliver the planned savings target.

Continued reliance on bank staffing to maintain safe staffing levels, manage vacancies, support urgent care pressures and cover sickness absence exists.

Metric ID: 10000101 Job Plans

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	80.6293	90	F	H	Executive Director of People and Culture



Narrative

The Job Plans metric is presented using an XmR statistical process control chart. Performance for August 2026 is 80.63%, which represents an improving position and is classified within the dashboard as "Improvement (High)". However, despite this positive trajectory, performance remains below the agreed target of 90.0%, resulting in a current assurance rating of Fail.

The SPC chart indicates sustained improvement compared with earlier periods, although the organisation has not yet reached the required compliance threshold. The recent upward movement suggests that actions being undertaken to increase completion and review of consultant job plans are having a positive effect. Continued focus is required to maintain this trajectory and close the remaining gap to target.

Given that performance remains below the required standard, priority should be placed on ensuring outstanding job plans are completed, reviewed and approved, particularly within specialties or divisions reporting lower compliance levels. Progress should continue to be monitored monthly through the Performance Framework and escalated where recovery trajectories are not being achieved.

Actions and Owners

Undertake targeted review of all outstanding consultant job plans and validate completion status by Clinical Board - Owner Medical Workforce, Job Planning Lead & AMD

Produce exception reports highlighting overdue or expired job plans and escalate through Board performance meetings - Owner Medical Workforce

Support specialties with historically lower compliance through dedicated job planning sessions and administrative support - Owner Medical Workforce, Job Planning Lead

Monitor progress through the Performance Management Framework and provide monthly updates to the People & Culture Committee - AD of MW

Develop recovery trajectories for any area below the 90% target and review progress at divisional performance meetings - Owner Medical Workforce, Job Planning Lead & AMD

Concerns

Job plan compliance remains at 80.63%, below the organisational target of 90.0%. Reduced assurance regarding workforce planning, activity planning and consultant accountability

Although SPC variation indicates improvement, the required level of compliance has not yet been achieved. Risk that expected benefits associated with job planning are not fully realised.

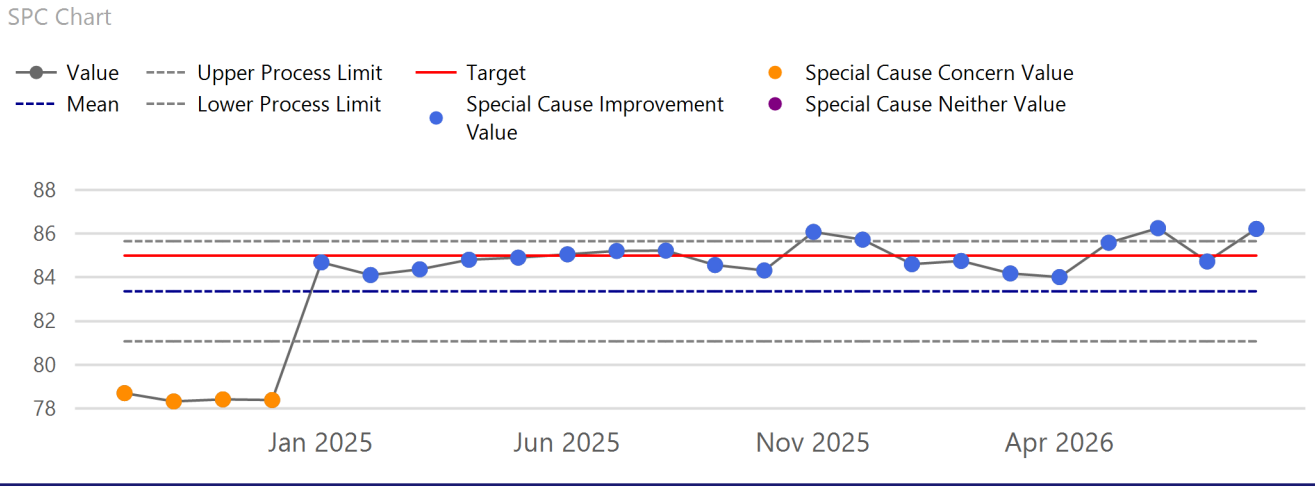
Incomplete or overdue job plans may limit visibility of programmed activities, service commitments and workforce capacity. Potential impact on workforce governance and operational planning.

No clinical lead as post/sessions currently vacant.

No medical workforce lead as existing member of staff has secured a new position so post is vacant.

Metric ID: 10000102 Medical Staff Appraisal

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	86.2205	85	?	H	Executive Director of People and Culture



Narrative

Medical Staff Appraisal compliance achieved 86.22% in August 2026, exceeding the organisational target of 85.0%. SPC analysis identifies the measure as demonstrating high improvement variation, indicating a positive shift in performance compared to the historic average. The latest reported position remains above target and suggests that improvement actions implemented across the organisation are having a sustained impact.

The XmR chart demonstrates evidence of performance improvement over time, with the latest reported value exceeding both the target threshold and the historical process mean. Whilst this provides increased assurance regarding appraisal compliance, the assurance rating remains reported as Hit or Miss, indicating that continued monitoring is required to ensure the improvement is sustained and embedded across all Clinical Boards and specialties.

Medical appraisal remains a key component of professional governance, supporting revalidation requirements and providing assurance regarding clinical practice, development needs and organisational compliance. Maintaining performance above target will require continued focus on timely completion of appraisals and proactive management of forthcoming appraisal due dates.

Actions and Owners

Review medical staff appraisal compliance by Clinical Board and identify individuals approaching appraisal expiry dates - Owner Medical Director and Clinical Board Medical Directors

Maintain a rolling appraisal monitoring process and issue reminders to appraisees and appraisers - Owner Revalidation & Medical Workforce Team

Escalate overdue appraisals through Clinical Board governance arrangements where completion dates are missed - Owner Clinical Board Medical Directors

Provide targeted support to specialties with emerging reductions in compliance to sustain performance above target - Owner Responsible Officers / Revalidation Team

Report appraisal compliance performance through the Integrated Performance Report and People & Culture Committee - Owner Associate Director of Medical Workforce & Resourcing

Concerns

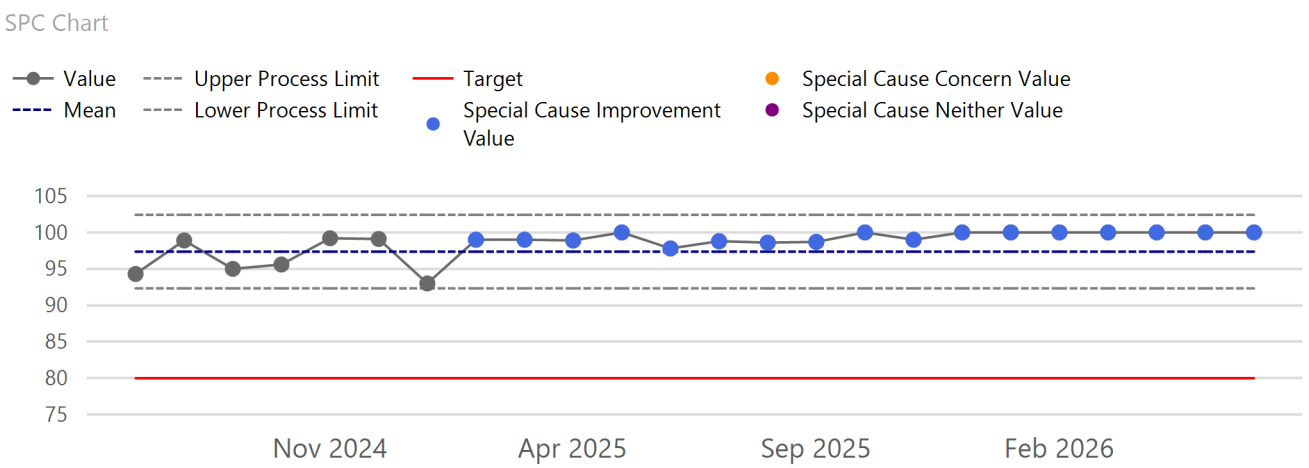
Although current performance exceeds the target, appraisal compliance remains vulnerable to fluctuations due to the cyclical nature of appraisal activity and the requirement to maintain consistent participation across all medical staff groups. There is a risk that compliance could deteriorate if outstanding appraisals are not completed promptly or if forthcoming appraisal activity is not effectively planned and monitored.

Continued scrutiny is therefore required to ensure the recent improvement in performance is sustained over the longer term and that compliance levels remain above the organisational target.

Metric ID: 10000015

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	100	80	P	H	Chief Operating Officer



Narrative

Consistently exceeding the standard, many months at 100% compliance

Actions and Owners

Sustained 100% compliance with Part 1A and Part 1B has been achieved through robust demand and capacity management, flexible deployment of clinical resource and continuous review of service capacity in response to changing demand. Psychoeducation Connection Contacts provide children and young people with earlier access to intervention while supporting delivery of the 28-day Part 1B standard

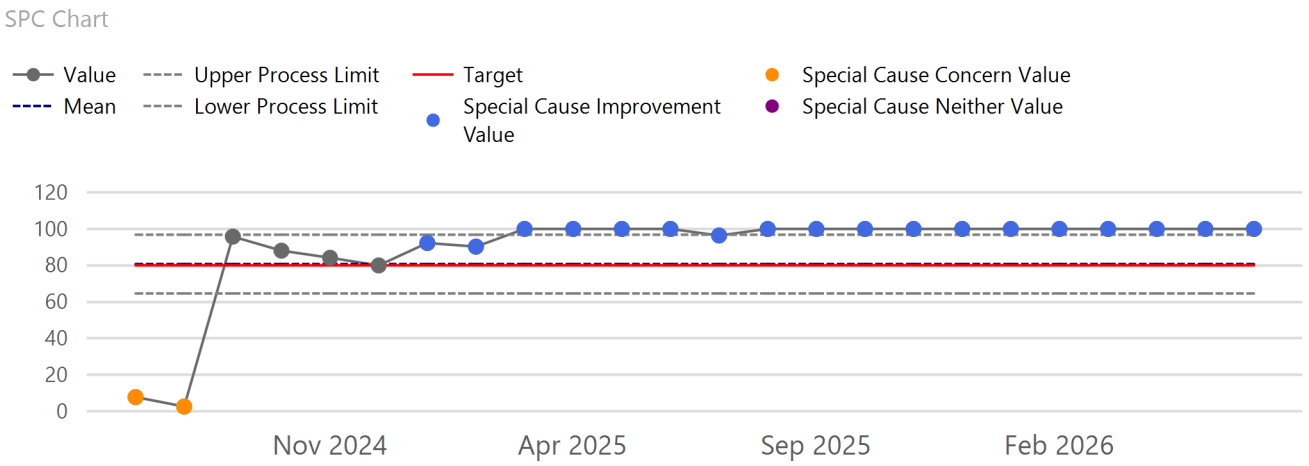
Concerns

n/a

Metric ID: 10000016

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	100	80	?	H	Chief Operating Officer



Narrative

Consistently exceeding the standard, many months at 100% compliance

Actions and Owners

Sustained 100% compliance with Part 1A and Part 1B has been achieved through robust demand and capacity management, flexible deployment of clinical resource and continuous review of service capacity in response to changing demand. Psychoeducation Connection Contacts provide children and young people with earlier access to intervention while supporting delivery of the 28-day Part 1B standard

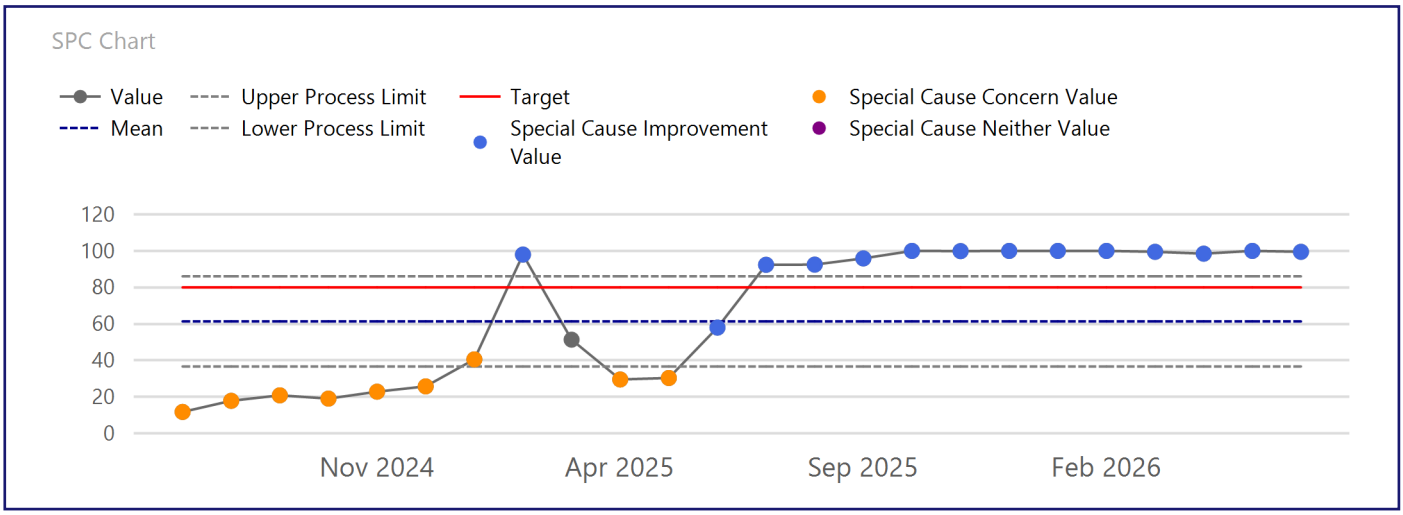
Concerns

n/a

Metric ID: 10000017

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	99.5	80	?	H	Chief Operating Officer



Narrative

Consistently exceeding the target

Actions and Owners

Internal flexibility to ensure sufficient assessments are completed

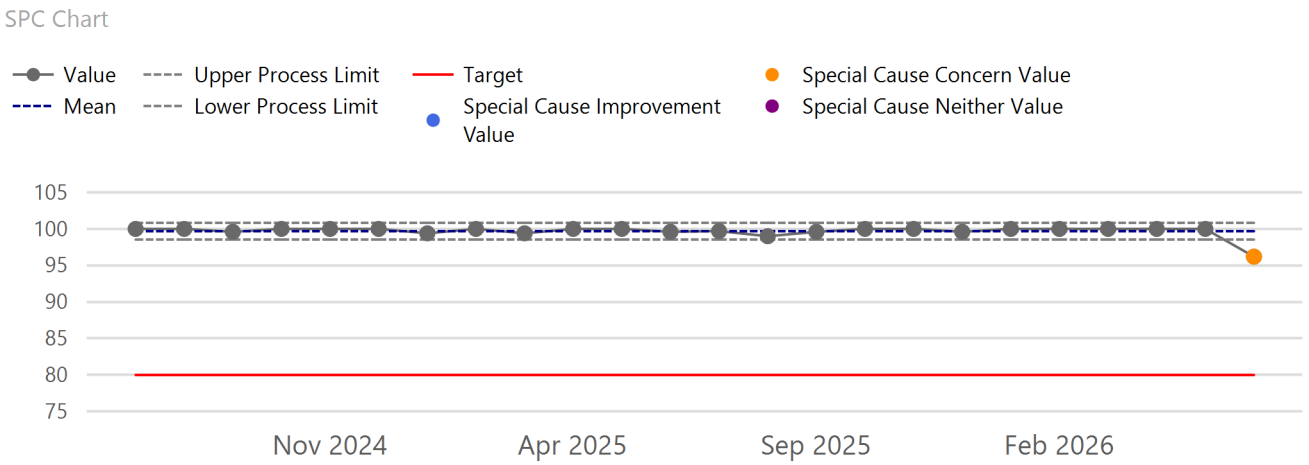
Concerns

Rise in long term sickness absence in PMHSS

Metric ID: 10000018

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	96.2	80	P	L	Chief Operating Officer



Narrative

Consistently exceeding the target

Actions and Owners

Development of more open access groups
Targeted work with highest referring GP clusters

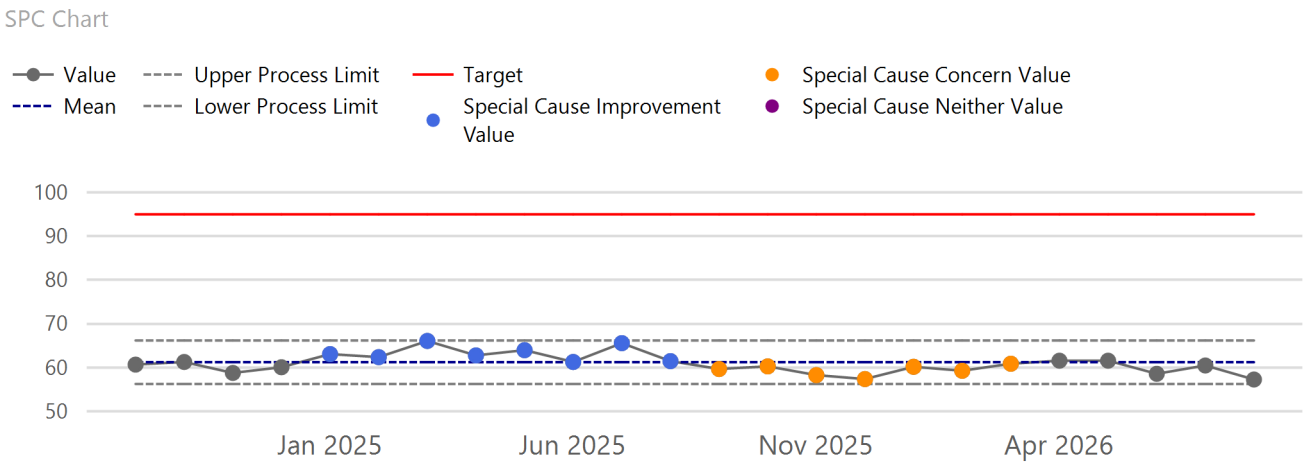
Concerns

Rise in long term sickness absence in PMHSS

Metric ID: 10000023

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	57.3	95	F		Chief Operating Officer



Narrative

No meaningful changes through the year but reduced compliance noted during periods of operational pressures.

Actions and Owners

Continued maximisation of MSDEC activity including acute physician pull from ambulatory directly into SDEC.
Development of SPoA, Safe@Home now incorporated to support alternative to EU attendances.
Implementation of 'Prism' flow recommendations.
Actions and performance metrics monitored through UEC Programme Board.

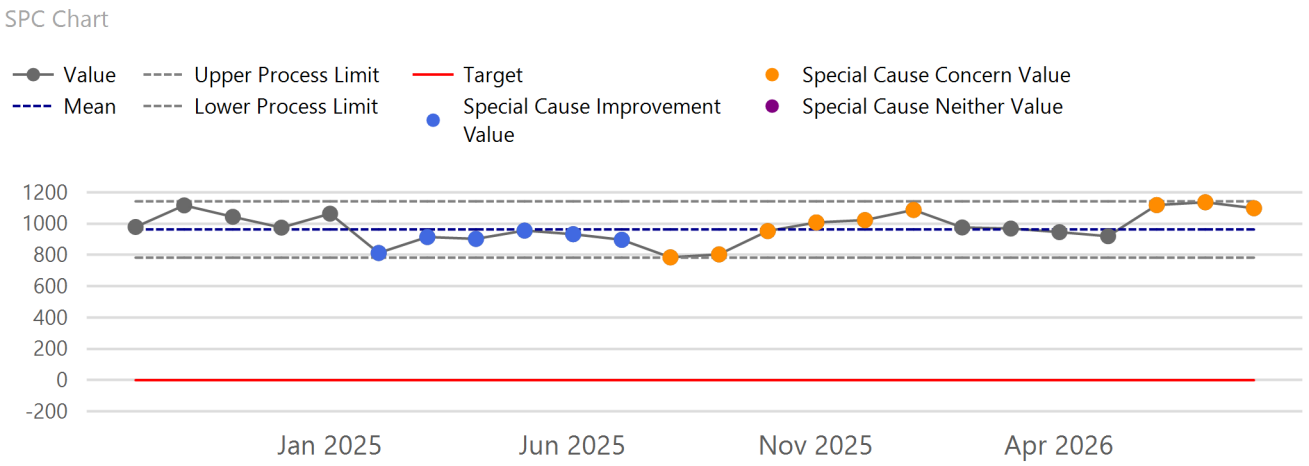
Concerns

No Health Board is meeting this standard

Metric ID: 10000024

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	1099	0	F	H	Chief Operating Officer



Narrative

No meaningful changes through the year but increases noted during periods of operational pressures, including past 2 months. We are routinely reporting over 800 12-hour breaches each month

Actions and Owners

Continued maximisation of MSDEC activity including acute physician pull from ambulatory directly into SDEC.
Development of SPoA, Safe@Home now incorporated to support alternative to EU attendances.
Implementation of 'Prism' flow recommendations.
Actions and performance metrics monitored through UEC Programme Board.

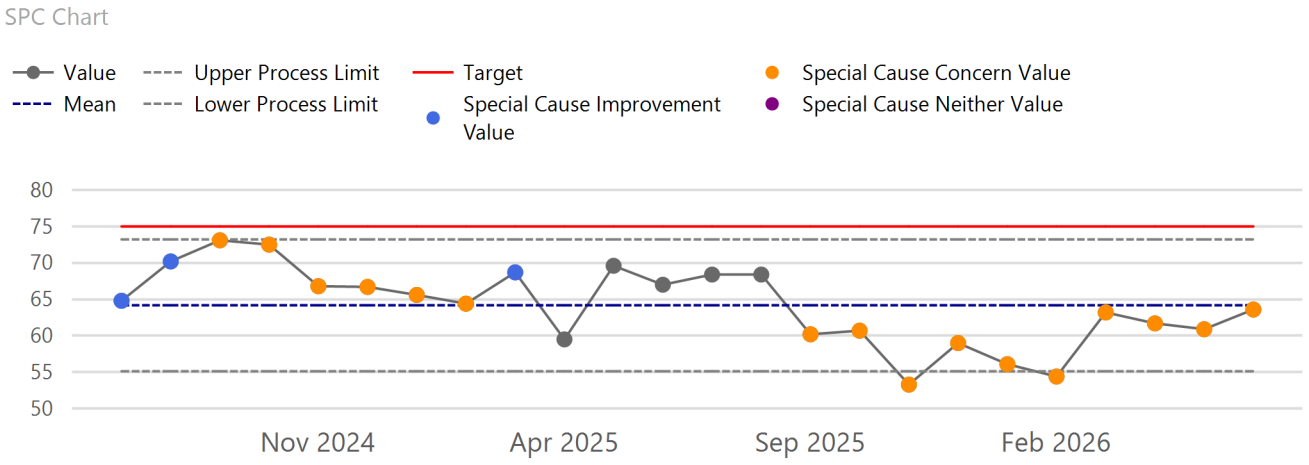
Concerns

Increased breach numbers during periods of high escalation.
We are not meeting our de-escalation criteria

Metric ID: 10000025

Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	63.6	75	F	L	Chief Operating Officer



Narrative

Growth in the 62 day backlog and a reduction in SCP performance from August 2025 to February 2026

Maintained over 60% compliance since March 2026 following stabilisation of the skin waiting list with rebalanced capacity

We are not meeting the SCP standard of 75%

Actions and Owners

Trajectory to achieve SCP 75% compliance by Q4 underpinned by actions in key tumour sites:
Upper GI - Locum starting in July with 5 Consultants joining in Q2/Q3
Urology - new consultant post starting August
Skin - Specialty doctor and fellow recruitment in July, conversion of FU outpatient slots to cancer, working group development to review referral process
Review and update of Cancer governance structure/process

Concerns

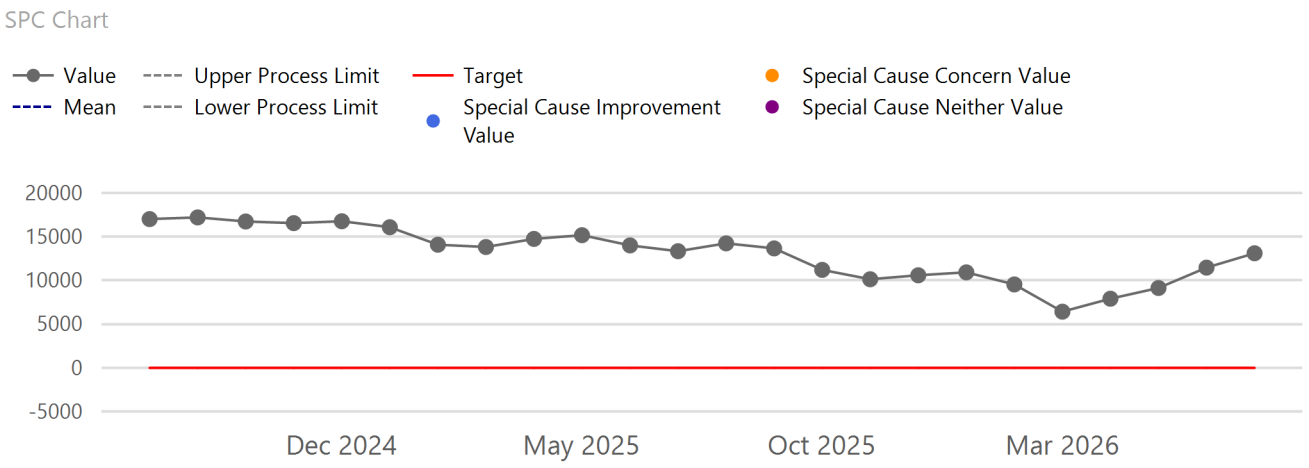
Increase in demand and total waiting list volume

Growth in backlog of patients waiting over 62 days for treatment

Sustainable capacity concerns in Upper GI, Urology and Skin

Metric ID: 10000026 Number of patients waiting more than 8 weeks for a specified diagnostic

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	13110	0	F		Chief Operating Officer



Narrative

Significant reduction in 8 week waits through 25/26, driven by improvements in Endoscopy and Radiology, despite increased demand as a result of the national outpatient insourcing programme. Cardiac imaging waits have increased as a result of the insourcing work, but the service have secured insourcing capacity to mitigate this. The 8 week position has increased since March driven by Cardiac imaging, NOUS and Endoscopy

Actions and Owners

Non-recurrent insourcing to support Cardiology

Endoscopy - insourcing secured to deliver cancer workload, capacity can be given to improve 8 week position. Llantrisant Health Park will provide recurrent capacity

Short term outsourcing and insourcing to support radiology position

An action plan is being developed with NHSP&I colleagues to secure investment for further diagnostic capacity

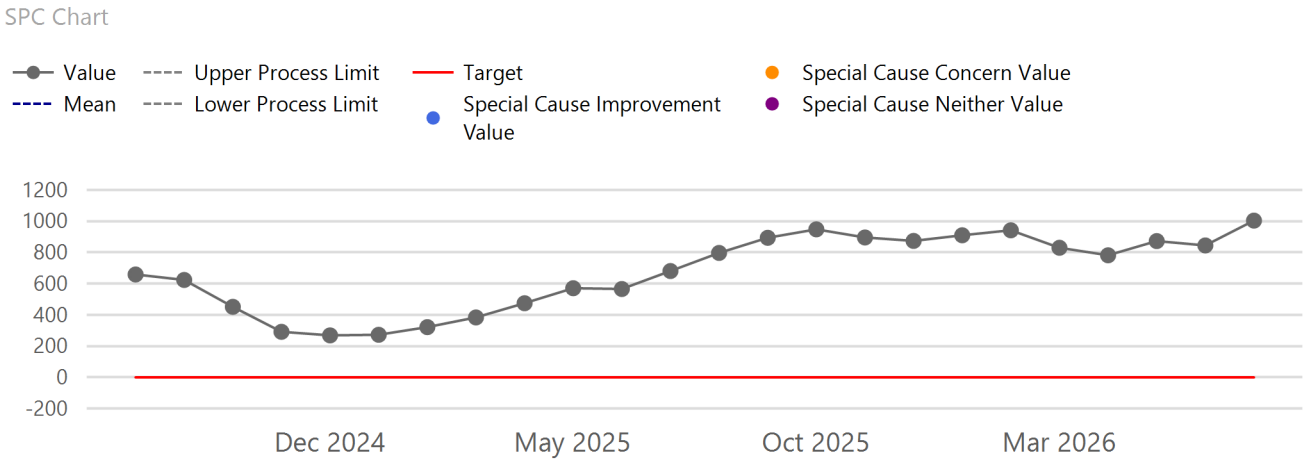
Concerns

Endoscopy and Radiology capacity

Metric ID: 10000028

Number of patients (all ages) waiting more than 14 weeks for a specified therapy

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	1004	0	F		Chief Operating Officer



Narrative

Total number of patients waiting over 14 weeks has fluctuated, breaches are clustered in Dietetics and Occupational Therapy. Overall >90% of patients are waiting less than 14 weeks for Therapy and we are consistently meeting our de-escalation requirement

Actions and Owners

Text reminders have been rolled out to drive down DNA/CAN rates

Implementation of See on Symptoms (SOS) and Patient Initiated Follow-Up (PIFU) pathways. This has been shown to reduce DNAs and allows FU capacity to be used for new patients

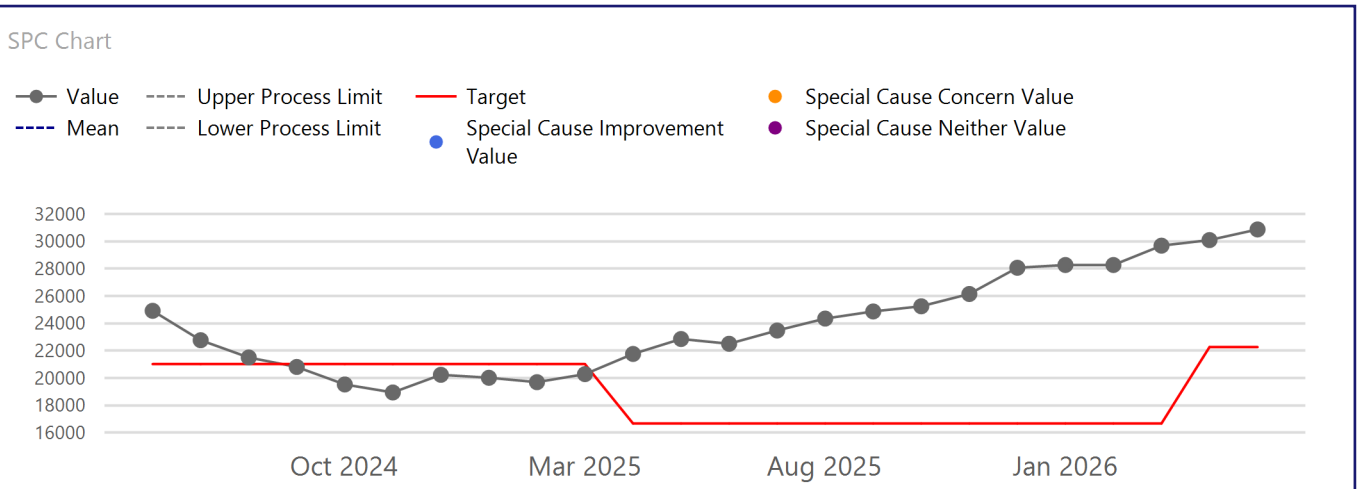
Concerns

Capacity shortfall in Dietetics and OT

Metric ID: 10000031

Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%

Latest Month	Value	Target	Assurance	Variation	Metric Owner
May 2026	30870	22261	F		Chief Operating Officer



Narrative

Uploaded data DRAFT not signed off

Actions and Owners

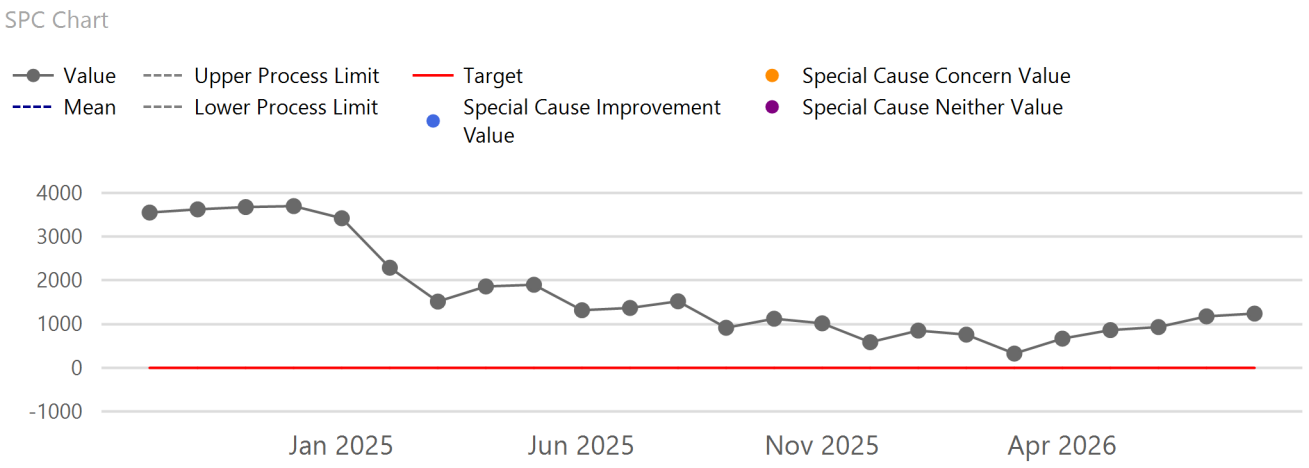
Conversion of un-booked, long waiting follow-ups to SOS/PIFU pathways in selected specialties. This will allow those patients needing follow-up to access an appointment in a timely manor through the see-on-symptoms and patient-initiated follow-up models

Concerns

Risks within follow-up cycle

Metric ID: 10000032 Number of patients waiting more than 104 weeks for referral to treatment

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	1242	0	F		Chief Operating Officer



Narrative

The number of 2-year waits reduced significantly through 25/26 - additional activity funded non-recurrently. March 2026 saw 2-year waits reduce to their lowest level since April 2021 and the elimination of 3-year waits. The number of patients waiting 2-years for treatment has increased since April, driven mainly by Dermatology, General Surgery and Orthopaedics

Actions and Owners

In line with the most recent correspondence from Welsh Government regarding funding for planned care recovery, we are working on plans both internally and with regional partners to eliminate 2-years waits in as many specialties as possible across the region.
Increased focus on productivity and efficiency, through clinical board level and Executive chaired Productivity and Efficiency Board.

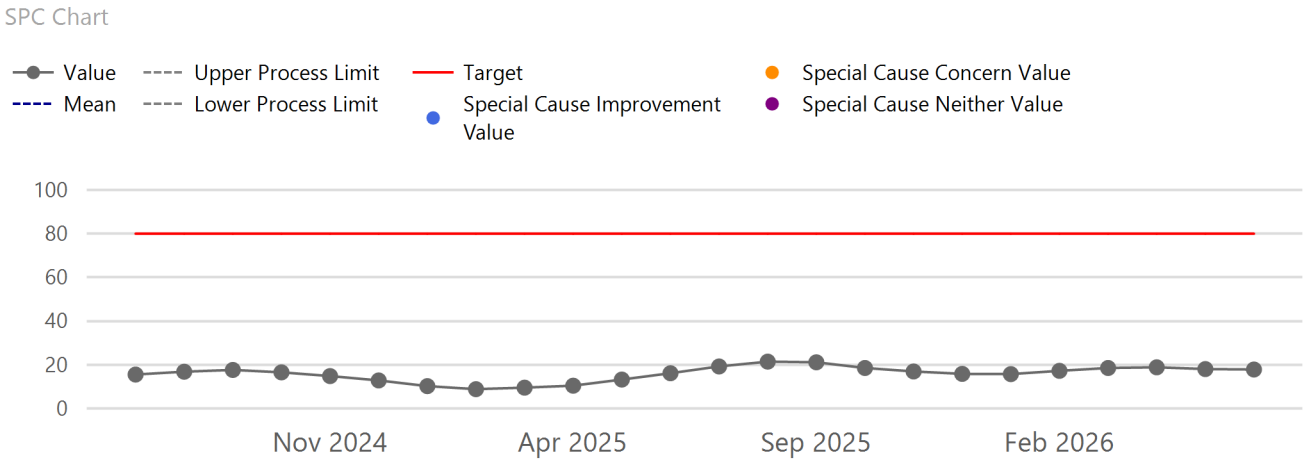
Concerns

Unable to meet required reductions without additional activity

Metric ID: 10000034

Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	17.9	80	F		Chief Operating Officer



Narrative

Performance remains consistently under the standard with capacity unable to match increasing demand for assessments. Despite this, a large amount of work has been undertaken over the past 2 years to transform the referral pathway, to reduce waiting times and support children and families waiting for assessment. These actions include:
-Referral pack includes clearer guidance and signposting pathway to support families while they are on the waiting list and reduce the risk of deterioration in the child's presentation
-Holistic approach across the ND pathway from referral. Whole-system approach has been embedded from triage through to full ND assessment - referrals are accepted for general neurodevelopmental concerns, with structured investigation into ASD, ADHD, and potential comorbidities at all stages to avoid repeat referrals.
-Development of an informed pathway for those children that at the time of the referral have already received input from different professionals and present clear features of ND conditions, to avoid to put them in the waitlist. These children will be given an outcome following a direct clinical contact soon after the referral has been processed
-Dedicated assessment pathways for young people aged 17 and over
-Making every contact count - stronger collaboration has been established across all services. A unified observation template has been drafted and is currently being trialled in OT and SALT to ensure consistent identification and recording of ND traits. Promotes seamless cross-referral and co-working between services

Actions and Owners

Non-recurrent money available for this year - currently assessing options for best use of this money within funding constraints. Additional actions to increase efficiencies and capacity:
Review of Consultant and Practitioner job planning to increase capacity by over 200 appointments/year
Clinical validation and new 'touch base' letters to allow those no longer needing the service to opt-out
Embed under 5s assessment protocol with dedicated SLT case note reviews. Reduced but does not remove requirement for 2nd assessment
Increased digitisation, including digital platforms for assessments and follow-up appointments
Continued engagement with Education

Performance is monitored within the Clinical Board and through the Clinical Board Executive Reviews

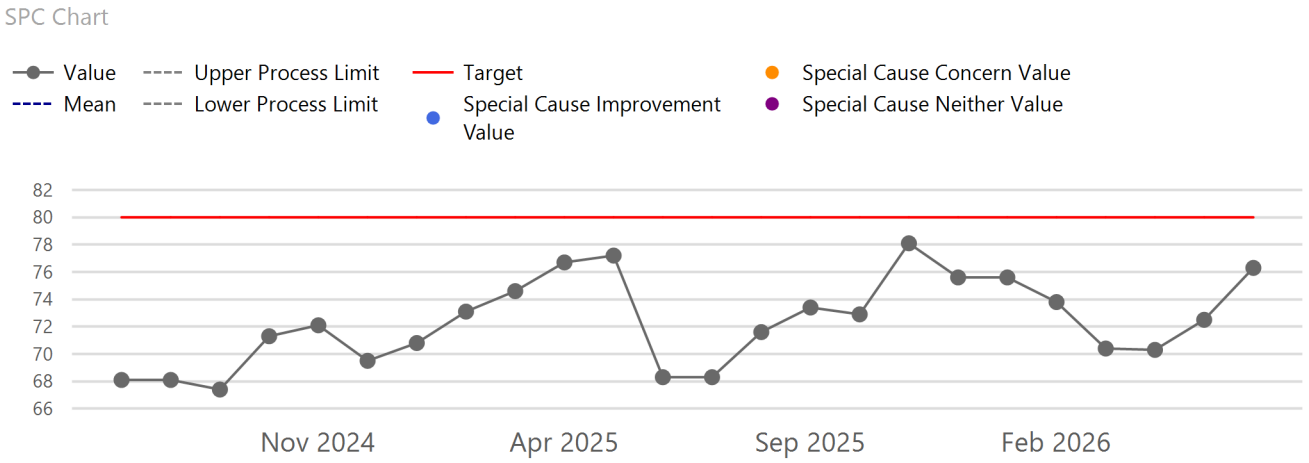
Concerns

Significant capacity shortfall under current model

Metric ID: 10000035

Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	76.3	80	F		Chief Operating Officer



Narrative

Not meeting standard. Second in Wales for compliance against this measure. Current performance impacted by number of waits in Complex PTSD and longer waits for the Traumatic Stress Service

Actions and Owners

Development of OAAT (One at a Time) pilot in CPTD service to reduce waiting times across the service. OAAT focusses on resolving one specific issue per appointment. Monitored through directorate and Clinical Board performance meetings

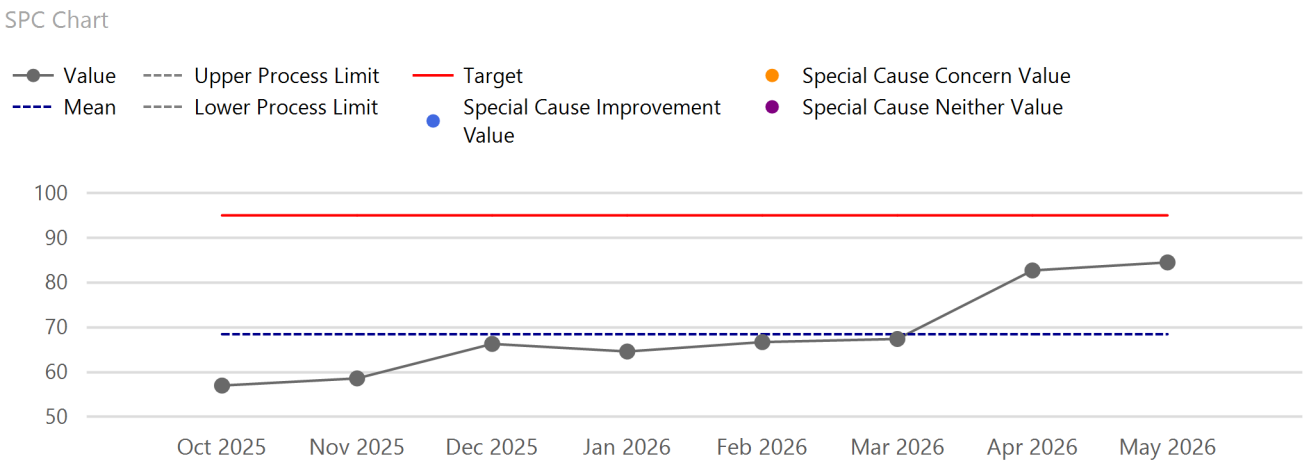
Concerns

Not meeting the standard

Metric ID: 10000041

Percentage of episodes clinically coded within one reporting month post episode discharge end date

Latest Month	Value	Target	Assurance	Variation	Metric Owner
May 2026	84.5	95			Chief Operating Officer



Narrative

Performance remains below the required target; however, sustained improvement has been achieved over the past two years.

Actions and Owners

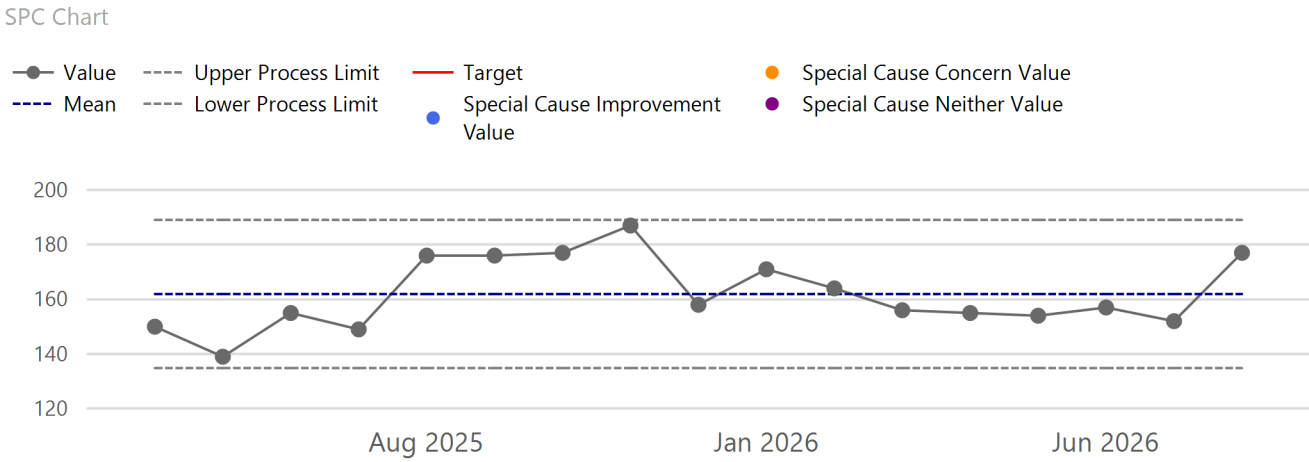
Recent improvements have been supported by enhanced staff retention, productivity improvements across the service, and the strategic deployment of a small number of highly experienced agency coders to supplement the establishment, strengthen skill mix and support ongoing service delivery.
Sustainable Clinical Coding Plan in development

Concerns

In May 2026 Audit Wales issued a follow-up audit report of the service in. Audit Wales recognised improvements in management arrangements, workforce stability and team culture; however, significant risks remain relating to workforce capacity, medical records, clinical engagement, governance, and sustained delivery of national performance standards. Six new recommendations were made and a Sustainable Clinical Coding Plan is now being developed.

Metric ID: 10000043 Number of Pathways of Care delayed discharges

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	177				Chief Operating Officer



Narrative

August saw an expected increase in overall numbers of POCD, although total bed days lost is reduced from this month last year. The average days delayed in August was 52

Actions and Owners

Implementation of 'Prism' flow recommendations
Discharge planning on arrival
Focus on Red to Green
Continue top 20 fortnightly review
Review of IDS/IDH workforce
Impact of actions monitored through UEC Programme Board

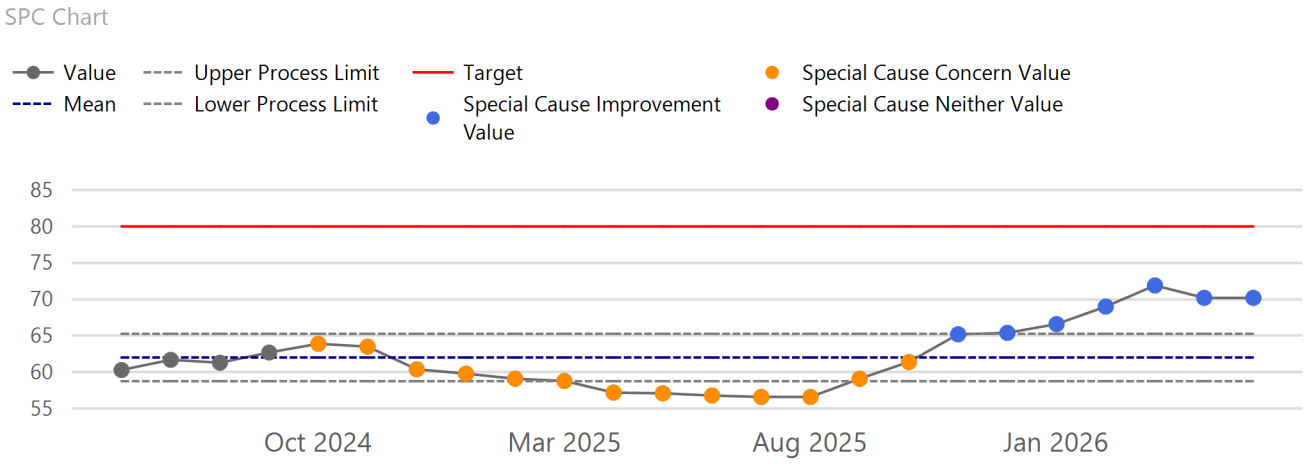
Concerns

Total delays remain higher than our de-escalation criteria

Metric ID: 10000045

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

Latest Month	Value	Target	Assurance	Variation	Metric Owner
May 2026	70.2	80	F	H	Chief Operating Officer



Narrative

Initial rapid process against action plan, recent plateau at c70% for overall compliance. The majority of teams are meeting the standard - actions are focussed on 2 CMHTs to improve their performance from c65%

Actions and Owners

Review and redistribute CTPs across all specialties within the teams.
Monitored through newly developed Power BI dashboard (weekly meetings). Monthly Directorate reviews and monthly Touchpoint with NHSP&I colleagues

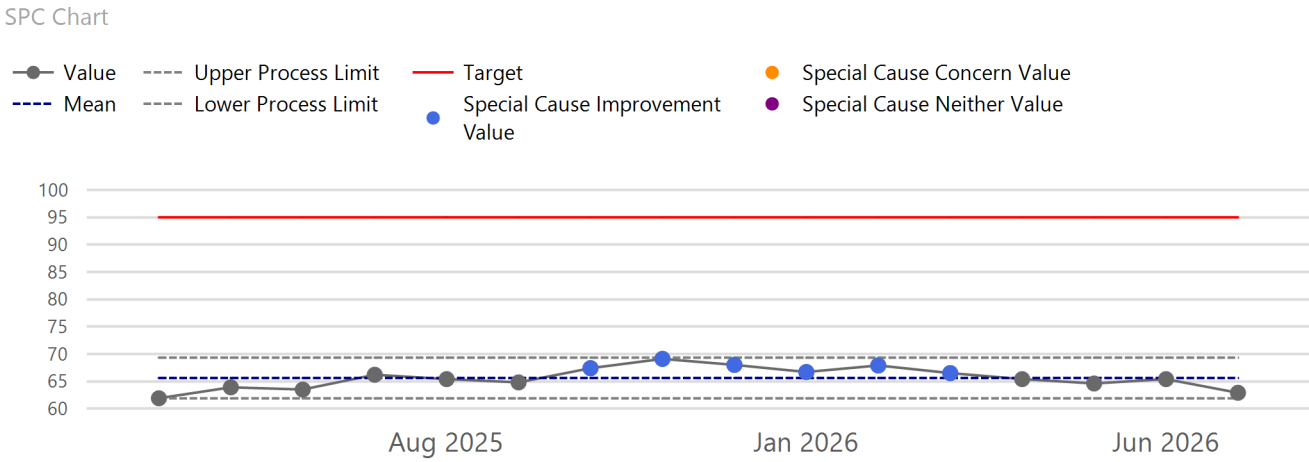
Concerns

Uneven distribution of incomplete CTPs leading to bottlenecks in completion

Metric ID: 10000051

Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	62.9	95	F		Chief Operating Officer



Narrative

Consistent performance but not always meeting de-escalation requirement. The R1 cohort is predominantly made up of Glaucoma and Medical Retina Patients. We have gone live with our Glaucoma Diagnostic Unit which will allow us to see all our R1 Glaucoma patients in a timely manner.

Actions and Owners

Progressing business case to increase capacity for Medical Retina patients.

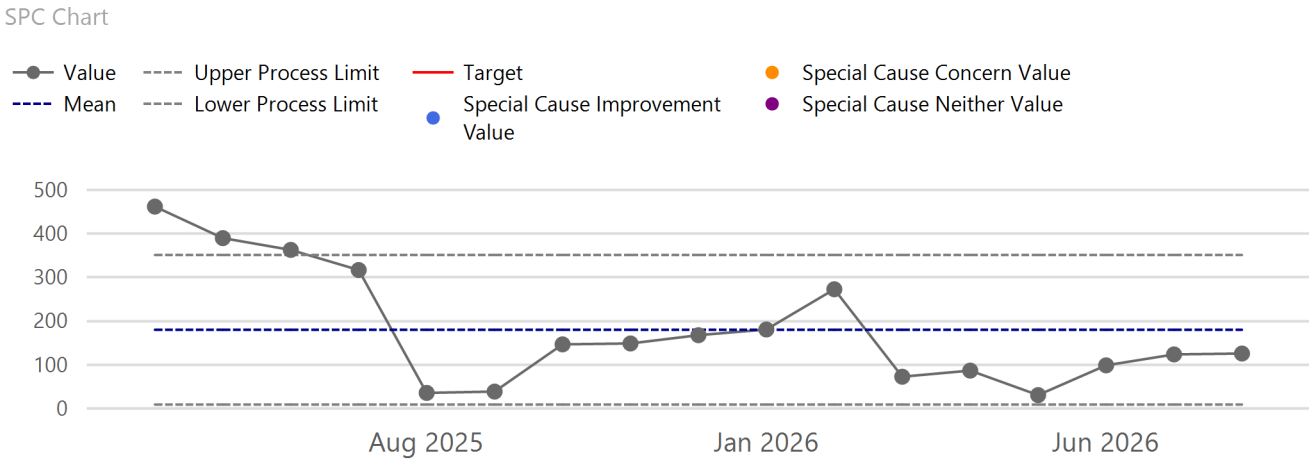
Working with Primary Care on pathway for Diabetic patients to reduce lower grade referrals and free capacity to see urgent patients in a more timely manner

Concerns

Not consistently meeting de-escalation requirement

Metric ID: 10000052 Number of ambulance patient handovers over one hour

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	126				Chief Operating Officer



Narrative

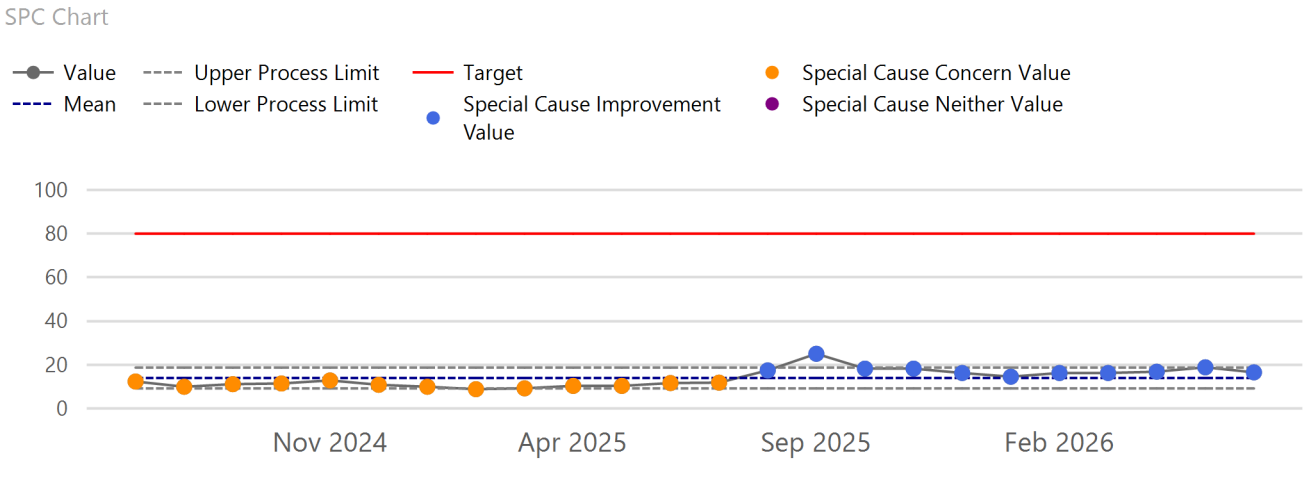
Uploaded data DRAFT not signed off

Actions and Owners

Concerns

Metric ID: 10000053 Percentage of ambulance patient handovers within 15 minutes

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	16.6	80	F	H	Chief Operating Officer



Narrative

No meaningful change - current operational priority is the 45-minute handover in line with the national requirements

Actions and Owners

Suite of actions to support EU and flow:
Update and refresh of acute referral policy
Escalation triggers moved to 15 and 30 minutes
ACU desk to coordinate timely clinical responses
Acute physician pull model from ambulatory areas direct to Medical SDEC
Phase 1 of acute remodel - frailty assessment
Actions and performance metrics monitored through UEC Programme Board

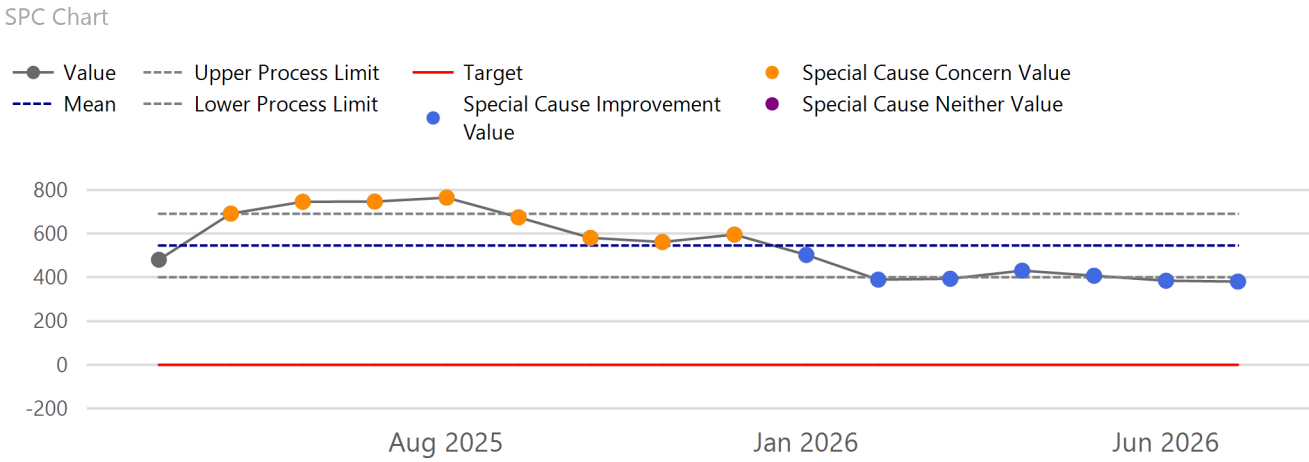
Concerns

Maintaining ambulance performance during periods of high escalation

Metric ID: 10000058

Number of children waiting more than 6 weeks for all audiology pathways (to include new assessment and intervention pathways)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	381	0	F	L	Chief Operating Officer



Narrative

We have seen an increase in the audiology waiting list through the last year driven by an increase in demand. 14 week waits have increased as capacity within the service is unable to match the increase. To mitigate some of this demand some staff time has been converted from the adult to the paediatric service. Clinical triage of referrals ensures urgent cases are identified and booked directly into the appropriate clinic

Actions and Owners

Service are developing a text reminder service to reduce DNAs and validate patients who no longer need an appointment

3 audiologist posts recruited - starts dates in Q2 and Q3 - providing additional capacity

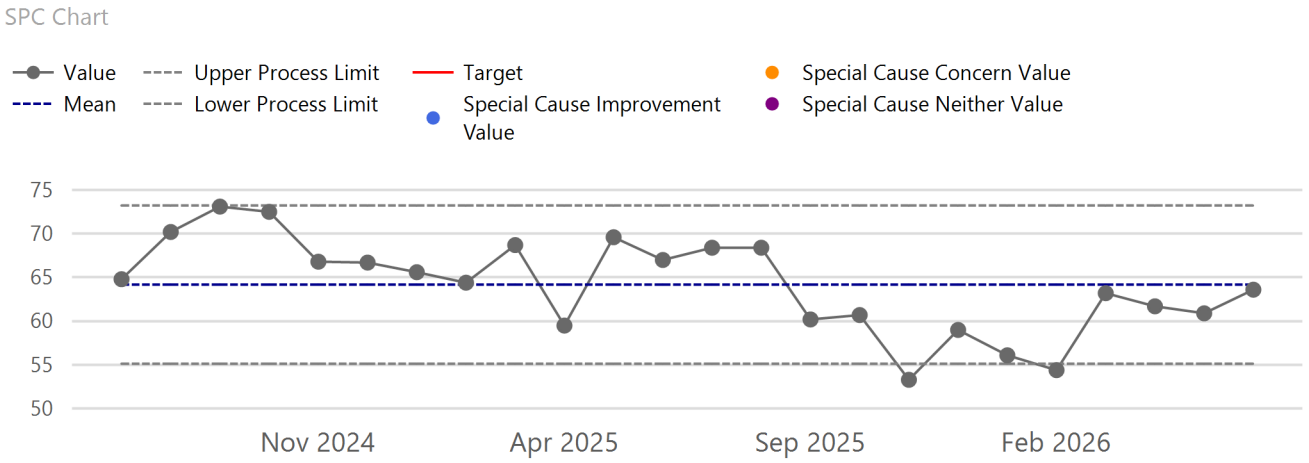
Concerns

Increasing demand and insufficient capacity to meet the waiting time standard

Metric ID: 10000113

% of patients starting first definitive cancer treatment within 62 days from point of suspicion

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	63.6				Chief Operating Officer



Narrative

Growth in the 62 day backlog and a reduction in SCP performance from August 2025 to February 2026

Maintained over 60% compliance since March 2026 following stabilisation of the skin waiting list with rebalanced capacity

We are not meeting the SCP standard of 75%

Actions and Owners

Trajectory to achieve SCP 75% compliance by Q4 underpinned by actions in key tumour sites:
Upper GI - Locum starting in July with 5 Consultants joining in Q2/Q3
Urology - new consultant post starting August
Skin - Specialty doctor and fellow recruitment in July, conversion of FU outpatient slots to cancer, working group development to review referral process
Review and update of Cancer governance structure/process

Concerns

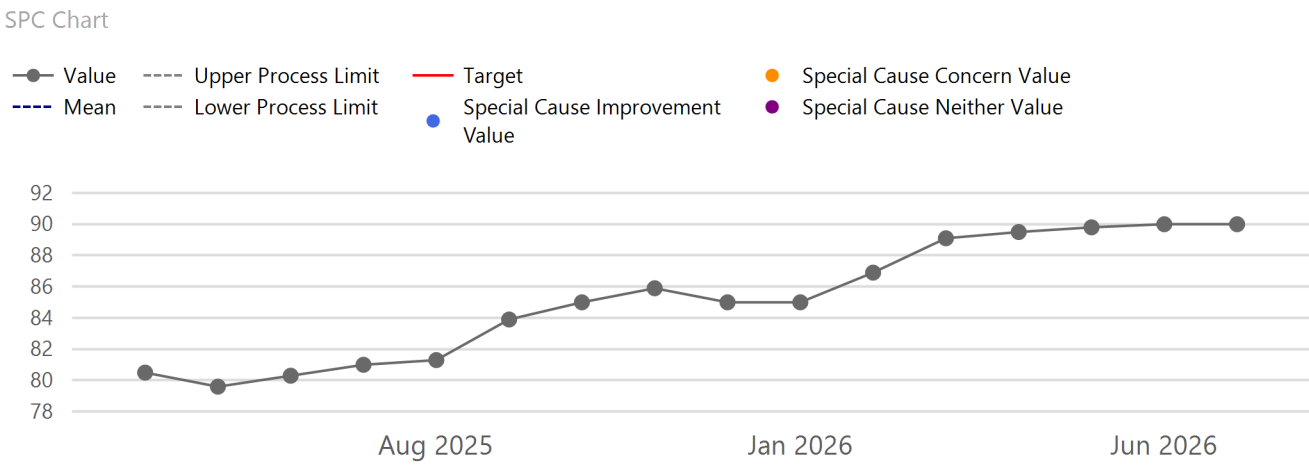
Increase in demand and total waiting list volume

Growth in backlog of patients waiting over 62 days for treatment

Sustainable capacity concerns in Upper GI, Urology and Skin

Metric ID: 10000114 100% of open outpatient pathways to be waiting less than 52 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	90				Chief Operating Officer



Narrative

Significant reduction in the volume of long waiting outpatients through last year as a result of the National and Local outpatient insourcing work. An additional 22k appointments were delivered through the national scheme, with a further 9k through C&V schemes. This activity ceased in March 2026 and we have maintained this improved position.

The use of SPC charts in not appropriate for the RTT measures - the format for this reporting will be reviewed locally and in line with the national reporting dashboard

Actions and Owners

Outpatient improvement summit in July 2026.
From Q3 - overbooking of outpatient clinics to mitigate the impact of patient DNAs.

Focus on use of SOS/PIFU to free up follow-up capacity for new patients

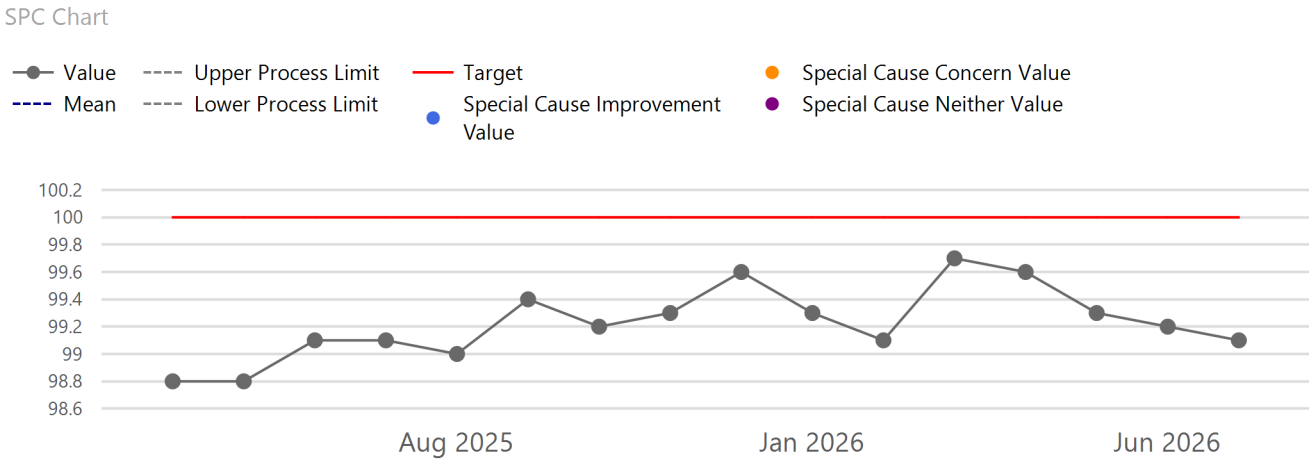
Actions and performance monitored through the newly establish Productivity and Efficiency Board

Concerns

Increase in the number of preaches in some specialties without additional activity

Metric ID: 10000115 100% of open pathways to be waiting less than 104 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	99.1	100	F		Chief Operating Officer



Narrative

The number of 2-year waits reduced significantly through 25/26 - additional activity funded non-recurrently. March 2026 saw 2-year waits reduce to their lowest level since April 2021 and the elimination of 3-year waits. The number of patients waiting 2-years for treatment has increased since April, driven mainly by Dermatology, General Surgery and Orthopaedics

Actions and Owners

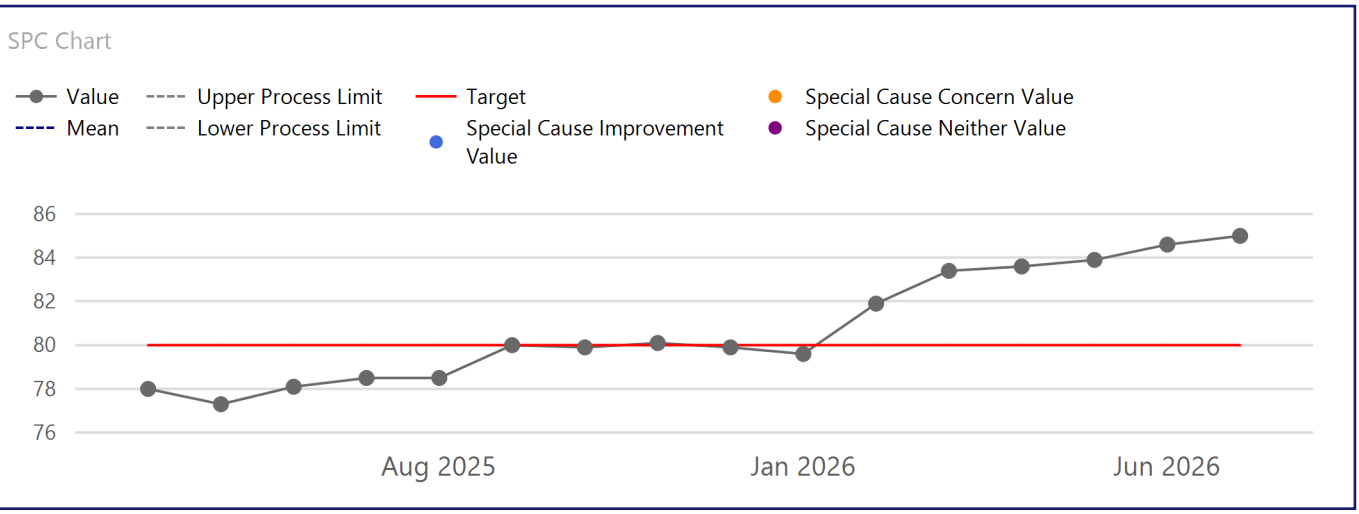
In line with the most recent correspondence from Welsh Government regarding funding for planned care recovery, we are working on plans both internally and with regional partners to eliminate 2-years waits in as many specialties as possible across the region.
Increased focus on productivity and efficiency, through clinical board level and Executive chaired Productivity and Efficiency Board.

Concerns

Unable to meet required reductions without additional activity

Metric ID: 10000116 80% of open pathways to be waiting less than 52?weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	85	80	P		Chief Operating Officer



Narrative

The proportion of open pathways <52 weeks increased last year through a combination of the national outpatient insourcing programmes and additional activity focussed on reducing 2 and 3-year waits for treatment. This work was consolidated with work on referral management. We have met the de-escalation standard since February

Actions and Owners

In line with the most recent correspondence from Welsh Government regarding funding for planned care recovery, we are working on plans both internally and with regional partners to eliminate 2-years waits in as many specialties as possible across the region.
Increased focus on productivity and efficiency, through clinical board level and Executive chaired Productivity and Efficiency Board.

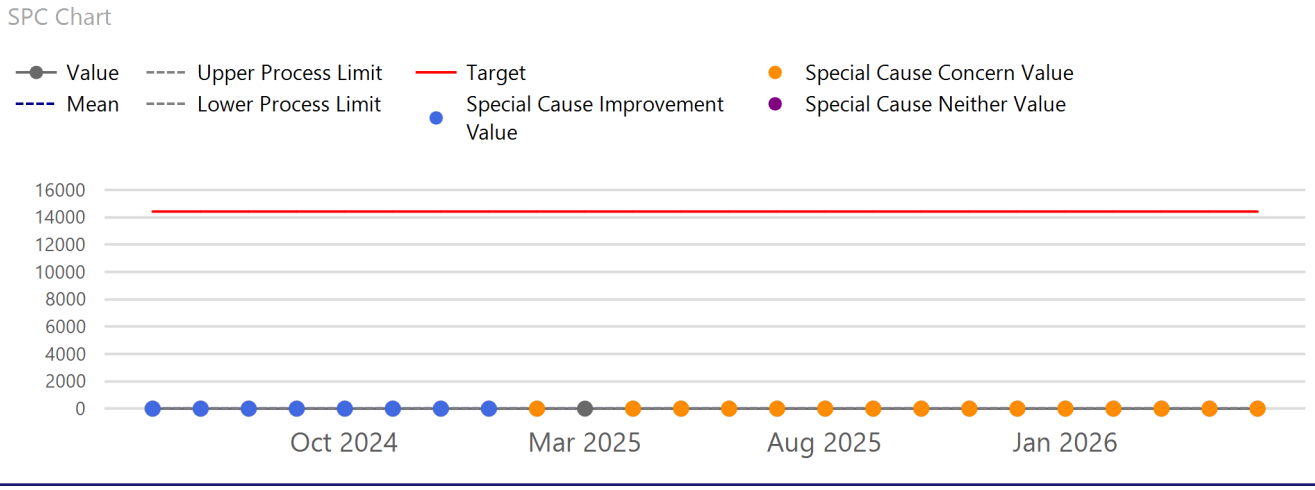
Concerns

Long waits to increase in some specialties without additional activity

Metric ID: 10000117

15% reduction in the number of patients delayed by 100% for their follow up appointment in 3 consecutive months (Based on baseline)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
May 2026	1	14415	P	H	Chief Operating Officer



Narrative

Consistently exceeding the target

Actions and Owners

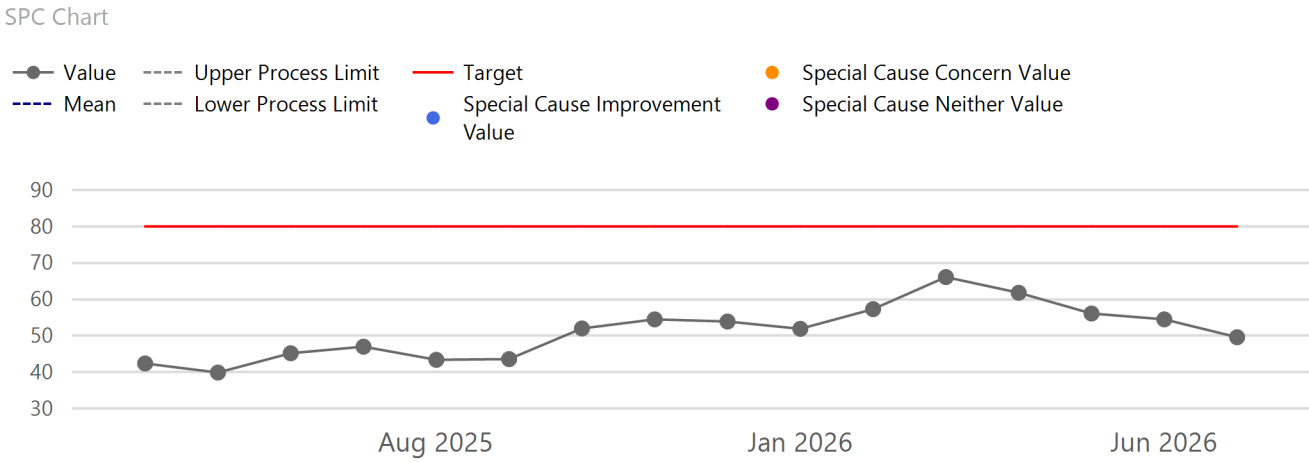
Internal flexibility to ensure sufficient assessments are completed

Concerns

Rise in long term sickness absence in PMHSS

Metric ID: 10000118 80% of patients waiting for a diagnostic test to be waiting less than 8 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	49.6	80	F		Chief Operating Officer



Narrative

Significant reduction in 8 week waits through 25/26, driven by improvements in Endoscopy and Radiology, despite increased demand as a result of the national outpatient insourcing programme. Cardiac imaging waits have increased as a result of the insourcing work, but the service have secured insourcing capacity to mitigate this. The 8 week position has increased since March driven by Cardiac imaging, NOUS and Endoscopy

Actions and Owners

Non-recurrent insourcing to support Cardiology

Endoscopy - insourcing secured to deliver cancer workload, capacity can be given to improve 8 week position. Llantrisant Health Park will provide recurrent capacity

Short term outsourcing and insourcing to support radiology position

An action plan is being developed with NHSP&I colleagues to secure investment for further diagnostic capacity

Concerns

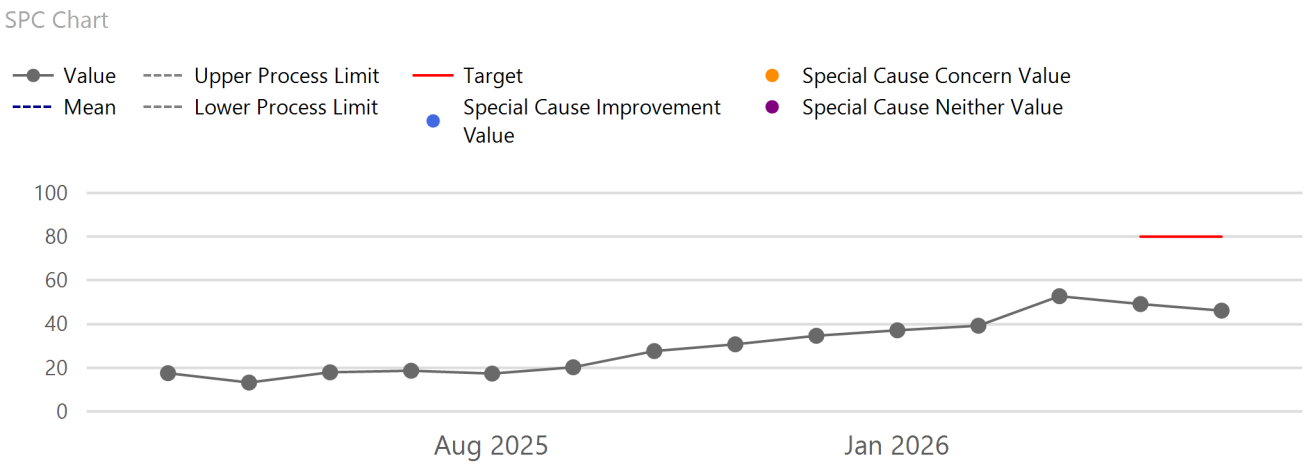
Endoscopy and Radiology capacity

We are consistently not meeting this de-escalation criteria

Metric ID: 10000119

80% of patients waiting for a diagnostic endoscopy to be waiting less than 8 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
May 2026	46.2	80	F		Chief Operating Officer



Narrative

Significant improvement through 25/26 - recurrent capacity issues remain, we are working with colleagues from NHSP&I to develop solutions

Actions and Owners

Insourcing secured to deliver cancer workload, capacity can be given to improve 8 week position. Llantrisant Health Park will provide recurrent capacity

An action plan is being developed with NHSP&I colleagues to secure investment for further diagnostic capacity

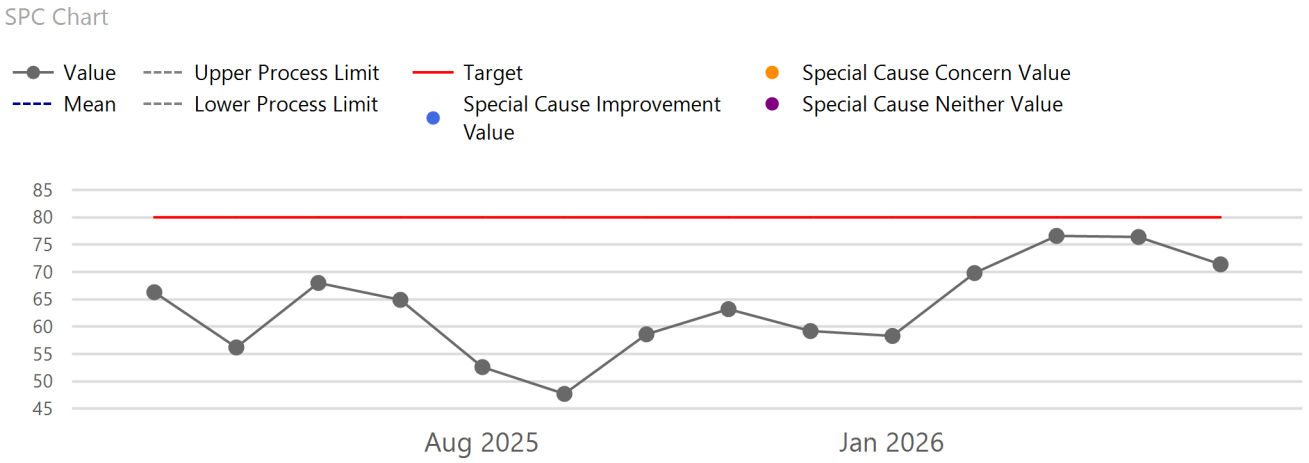
Concerns

Endoscopy capacity

We are consistently not meeting this de-escalation criteria

Metric ID: 10000120 80% of patients waiting for a non-cardiac MRI to be waiting less than 8 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
May 2026	71.4	80	F		Chief Operating Officer



Narrative

Improvement noted through Q3 and Q4 25/26 but we are consistently not meeting the standard. Insourcing has been secured to drive down the backlog from Q3 this year

Actions and Owners

Short term insourcing to help recover the backlog of long waits.

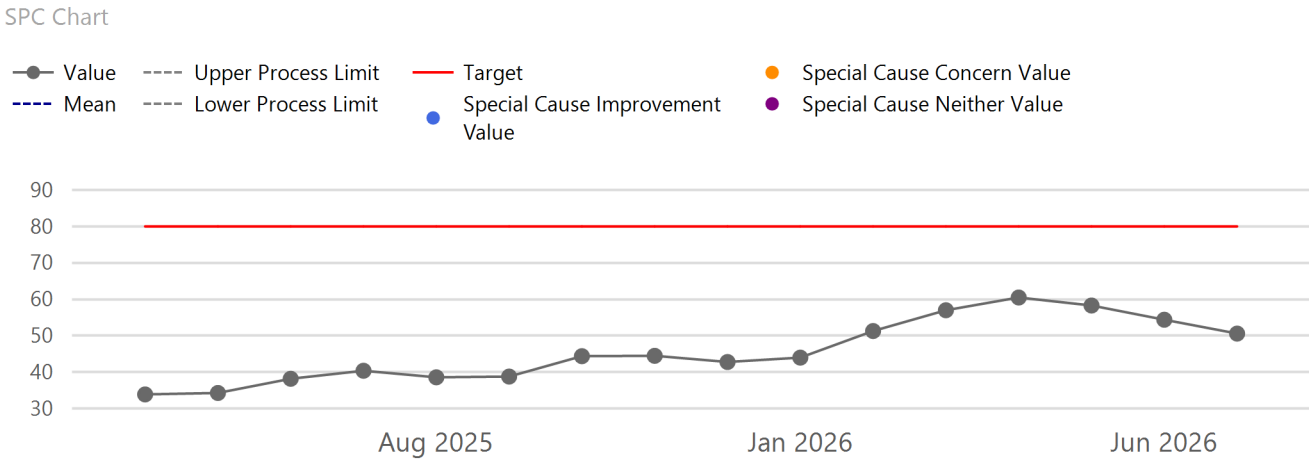
An action plan is being developed with NHSP&I colleagues to secure investment for further diagnostic capacity

Concerns

We are consistently not meeting this de-escalation criteria

Metric ID: 10000121 80% of patients waiting for a NOUS to be waiting less than 8 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	50.6	80	F		Chief Operating Officer



Narrative

Improvement noted through Q3 and Q4 25/26 but we are consistently not meeting the standard. There was a delay in commencement of the insourcing contract, which did not deliver contracted volumes.

Actions and Owners

Short term support for NOUS with outsourcing, long term plan for advanced sonographer training, build on learning from Swansea Bay UHB model.

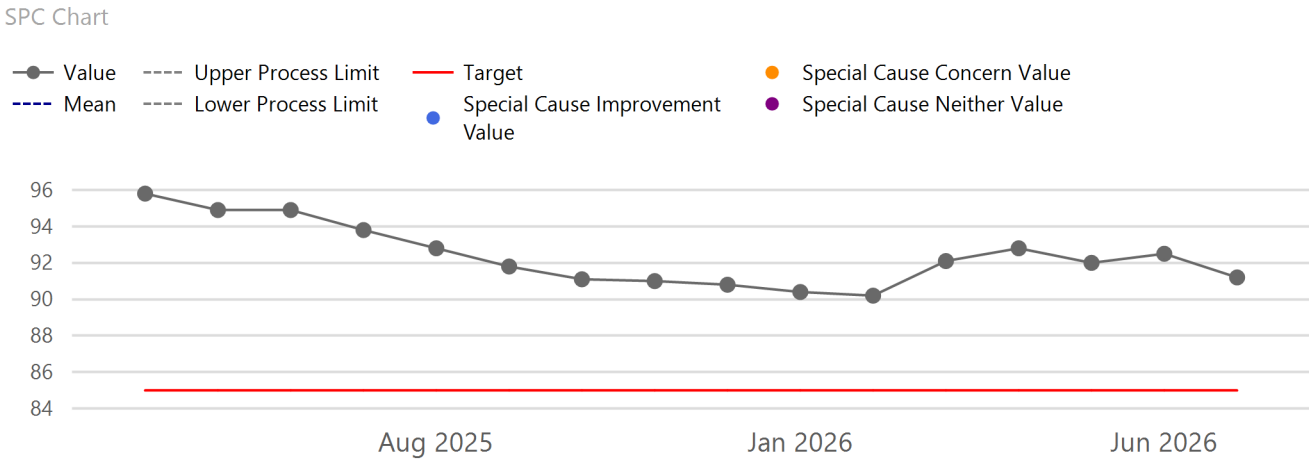
An action plan is being developed with NHSP&I colleagues to secure investment for further diagnostic capacity

Concerns

We are consistently not meeting this de-escalation criteria

Metric ID: 10000122 85% of patients waiting for therapies to be waiting less than 14 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	91.2	85	P		Chief Operating Officer



Narrative

Total number of patients waiting over 14 weeks has fluctuated, breaches are clustered in Dietetics and Occupational Therapy. Overall >90% of patients are waiting less than 14 weeks for Therapy and we are consistently meeting our de-escalation requirement

Actions and Owners

Text reminders have been rolled out to drive down DNA/CAN rates

Implementation of See on Symptoms (SOS) and Patient Initiated Follow-Up (PIFU) pathways. This has been shown to reduce DNAs and allows FU capacity to be used for new patients

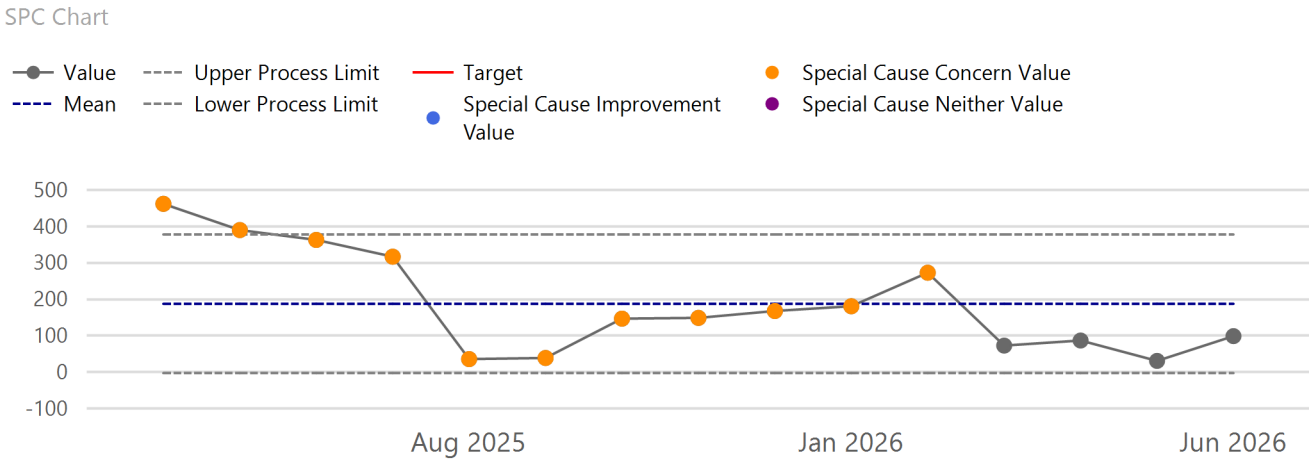
Concerns

Capacity shortfall in Dietetics and OT

Metric ID: 10000123

Continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months (based on agreed baseline)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	99				Chief Operating Officer



Narrative

Our current performance remains improved from last year, but we see fluctuations in line with operational pressures in the EU and across the inpatient and assessment areas. June saw an increase in 1-hour ambulance holds and an increase in the average handover time to 28 minutes from 24 minutes in May. Over half the 1-hour breaches came during the Business Continuity Incident at the end of the month. We are reviewing our data from across the health system over the past 8 weeks to better understand the impact of external and internal pressures.

Actions and Owners

Suite of actions to support EU and flow:
Update and refresh of acute referral policy
Escalation triggers moved to 15 and 30 minutes
ACU desk to coordinate timely clinical responses
Acute physician pull model from ambulatory areas direct to Medical SDEC
Phase 1 of acute remodel - frailty assessment
Actions and performance metrics monitored through UEC Programme Board

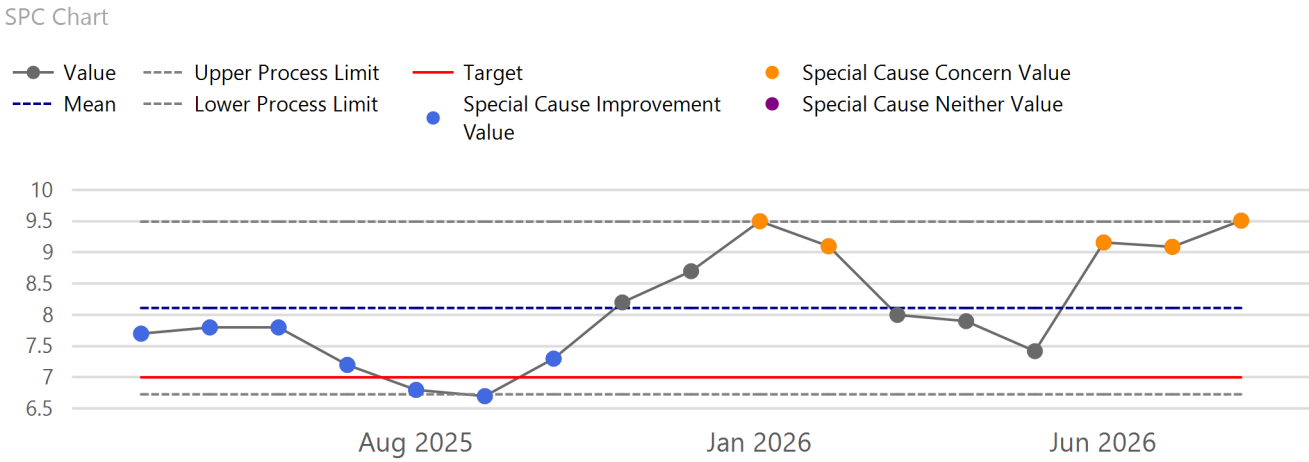
Concerns

Maintaining ambulance performance during periods of high escalation

Metric ID: 10000124

Continuous improvement towards no-more than 7% of patients waiting over 12 hours at each individual site and across the health board

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	9.51	7	?	H	Chief Operating Officer



Narrative

No meaningful changes through the year but increases noted during periods of operational pressures, including July and August. We are routinely reporting over 800 12-hour breaches each month

Actions and Owners

Continued maximisation of MSDEC activity including acute physician pull from ambulatory directly into SDEC.
Development of SPoA, Safe@Home now incorporated to support alternative to EU attendances.
Implementation of 'Prism' flow recommendations.
Actions and performance metrics monitored through UEC Programme Board.

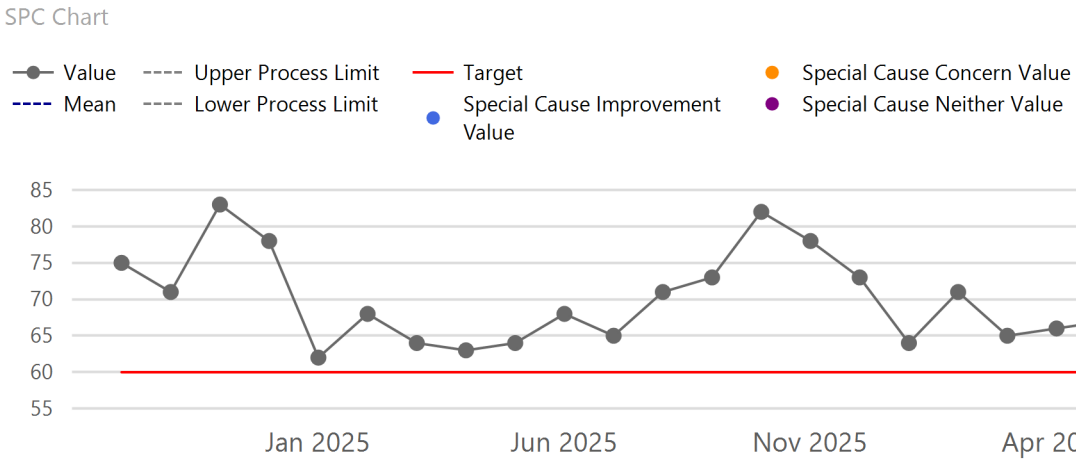
Concerns

Improving performance during periods of high escalation.
We are not meeting our de-escalation criteria

Metric ID: 10000125

Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60-minutes

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	73	60	F		Chief Operating Officer



Narrative

Improvement noted from Q3 last year but no meaningful changes in the last quarter. Periods of operational pressures through July and August have seen median time increase

Actions and Owners

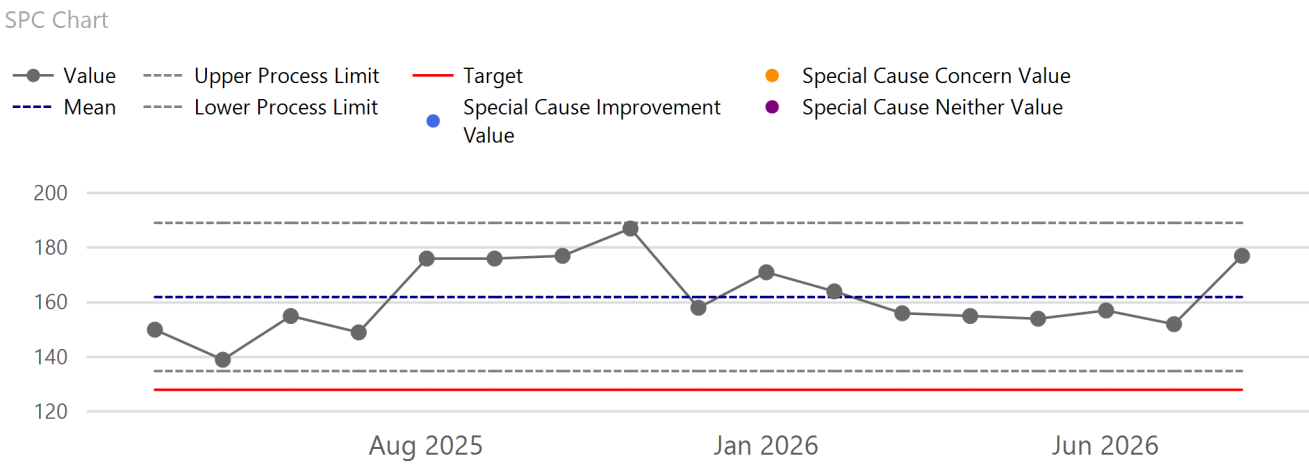
Continued maximisation of MSDEC activity.
Development of SPoA, Safe@Home now incorporated to support alternative to EU attendances.
ACU desk to coordinate timely clinical responses.
Actions and performance metrics monitored through UEC Programme Board.

Concerns

Maintaining performance during periods of high escalation.
We are not meeting our de-escalation criteria

Metric ID: 10000126 Continuous reduction in delayed pathways of 5% (based on agreed baseline)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	177	128	F		Chief Operating Officer



Narrative

August saw an expected increase in overall numbers of POCD, although total bed days lost is reduced from this month last year. The average days delayed in August was 52

Actions and Owners

Implementation of 'Prism' flow recommendations
Discharge planning on arrival
Focus on Red to Green
Continue top 20 fortnightly review
Review of IDS/IDH workforce
Impact of actions monitored through UEC Programme Board

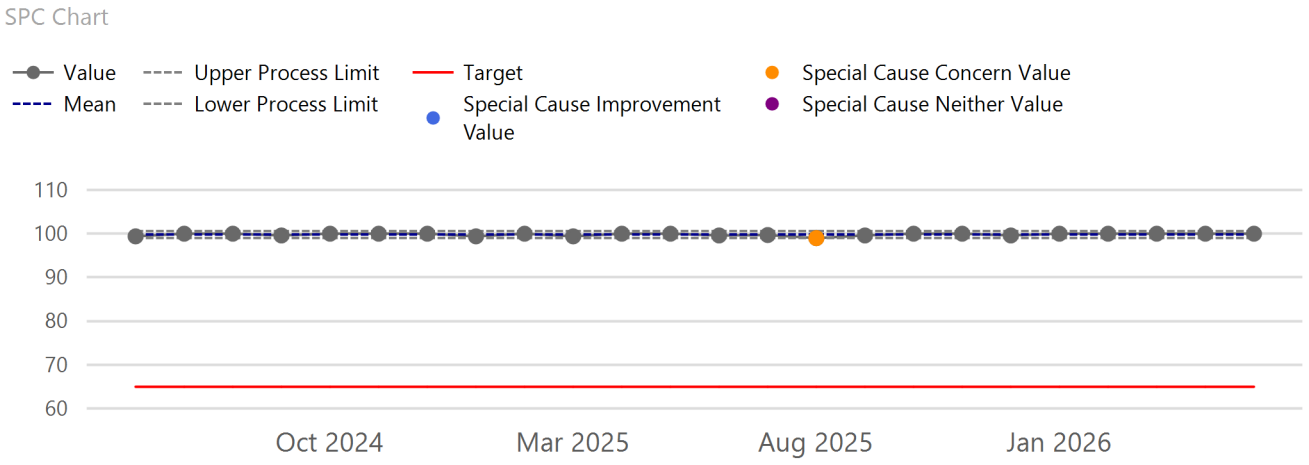
Concerns

Total delays remain higher than our de-escalation criteria

Metric ID: 10000127

65% of therapeutic interventions started within 28 days following an assessment by LPMHSS

Latest Month	Value	Target	Assurance	Variation	Metric Owner
May 2026	100	65	P		Chief Operating Officer



Narrative

Consistently exceeding the standard

Actions and Owners

Development of more open access groups
Targeted work with highest referring GP clusters

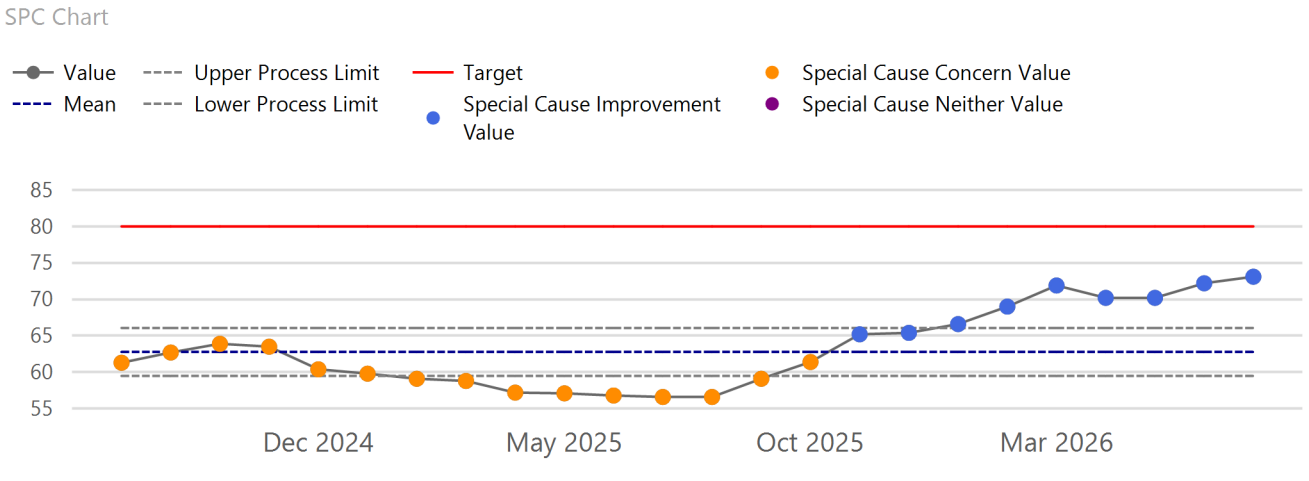
Concerns

Rise in long term sickness absence in PMHSS

Metric ID: 10000128

80% of HB residents in receipt of secondary mental health services who have a valid care and treatment plan

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	73.1	80	F	H	Chief Operating Officer



Narrative

Initial rapid process against action plan, recent plateau at c70% for overall compliance. The majority of teams are meeting the standard - actions are focussed on 2 CMHTs to improve their performance from c65%

Actions and Owners

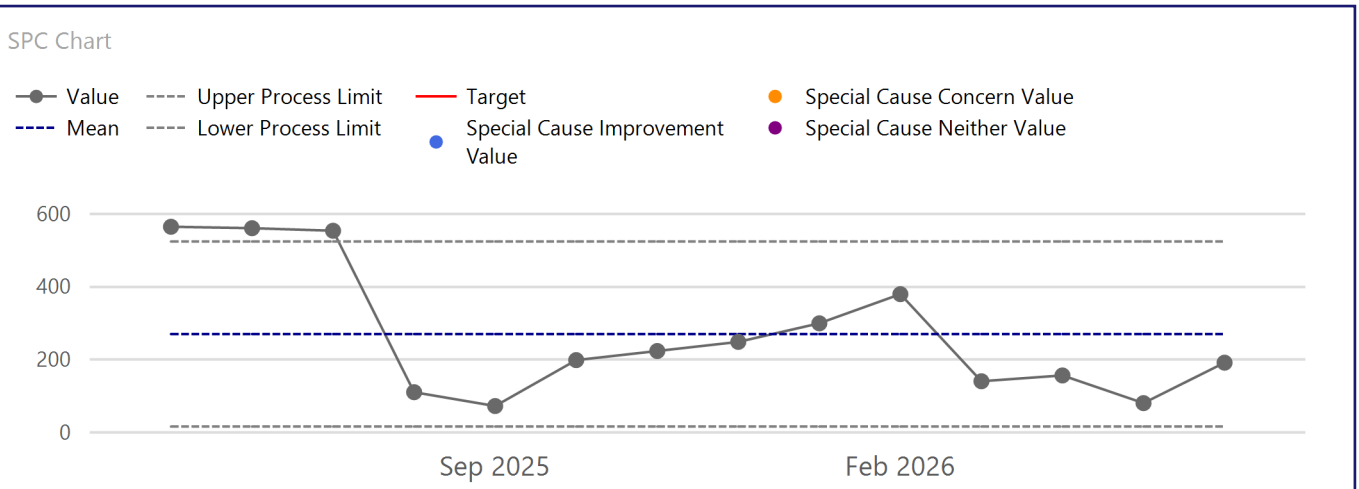
Review and redistribute CTPs across all specialties within the teams.
Monitored through newly developed Power BI dashboard (weekly meetings). Monthly Directorate reviews and monthly Touchpoint with NHSP&I colleagues

Concerns

Uneven distribution of incomplete CTPs leading to bottlenecks in completion

Metric ID: 10000129 45-minute ambulance handover delays

Latest Month	Value	Target	Assurance	Variation	Metric Owner
June 2026	192				Chief Operating Officer



Narrative

Our current performance remains improved from last year, but we see fluctuations in line with operational pressures in the EU and across the inpatient and assessment areas. In May 95% of handovers were completed within 45 minutes, this reduced to 88% in June and has remained at this level so far in July. We continue to focus on urgent and emergency care as we look to maintain this improvement with our ambition this year to maintain at least 95% of handovers within 45 minutes. All 45 minutes breaches are audited on a weekly basis

Actions and Owners

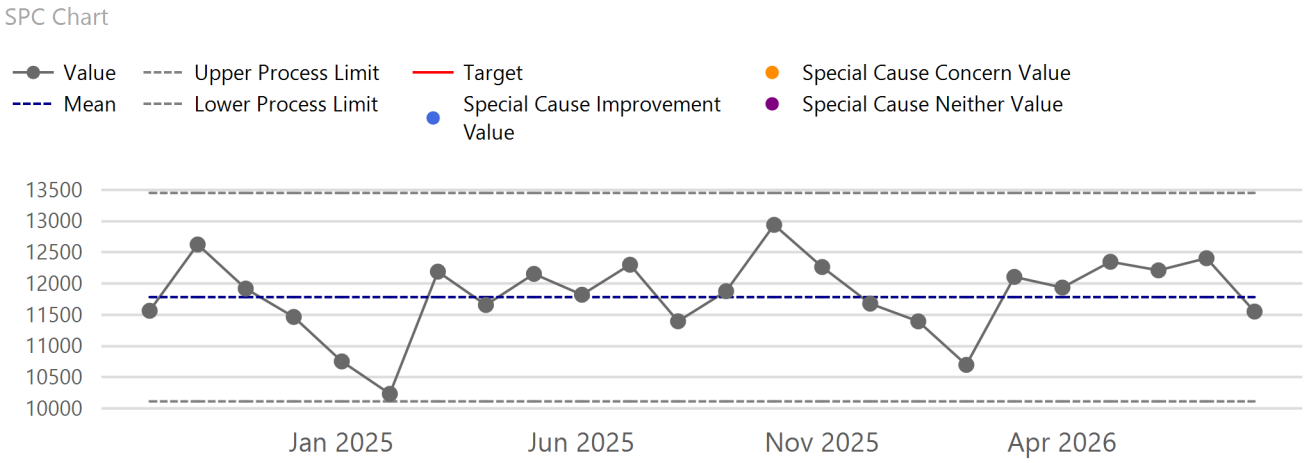
Suite of actions to support EU and flow:
Update and refresh of acute referral policy
Escalation triggers moved to 15 and 30 minutes
ACU desk to coordinate timely clinical responses
Acute physician pull model from ambulatory areas direct to Medical SDEC
Phase 1 of acute remodel - frailty assessment
Actions and performance metrics monitored through UEC Programme Board

Concerns

Maintaining ambulance performance during periods of high escalation

Metric ID: 10000130 Emergency unit attendances

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	11554				Chief Operating Officer



Narrative

Metric provided for information. The C&V approach for reporting against these measures will be reviewed in Q3

Actions and Owners

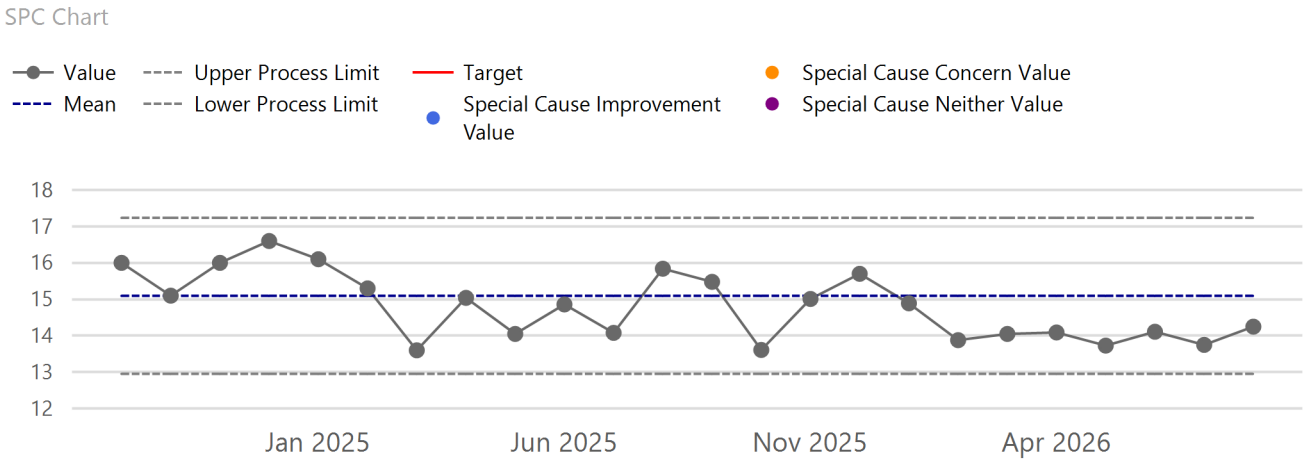
n/a

Concerns

n/a

Metric ID: 10000131 % of EU attendances that results in an admission to hospital

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	14.25				Chief Operating Officer



Narrative

Metric provided for information. The C&V approach for reporting against these measures will be reviewed in Q3

Actions and Owners

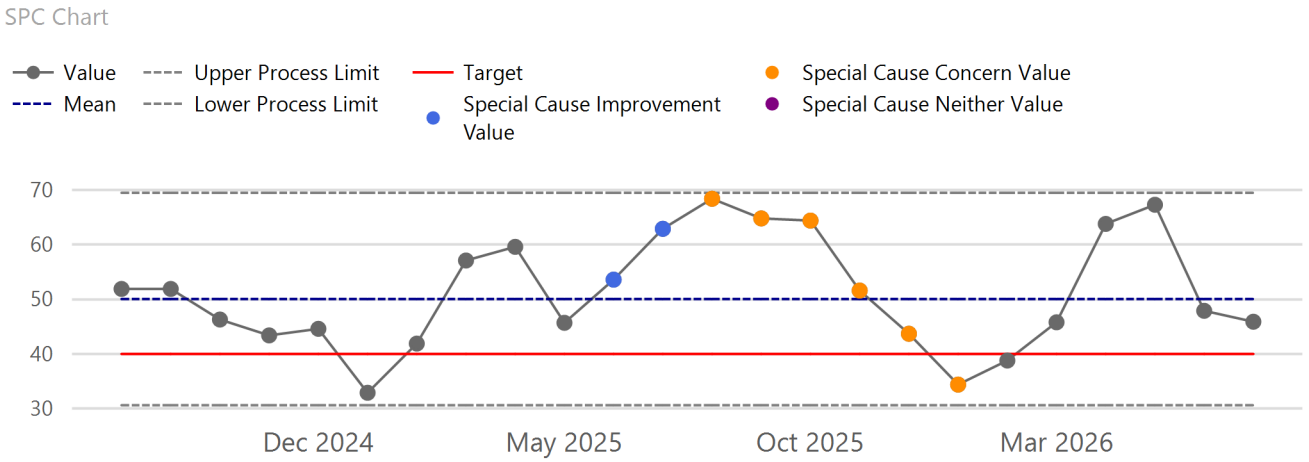
n/a

Concerns

n/a

Metric ID: 10000136 % of stroke admissions within 4 hours of arrival

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	45.9	40			Chief Operating Officer



Narrative

Performance has fluctuated in line with wider operational pressures in Emergency Unit, current performance remains above the all Wales average and SSNAP average, but we continue to review and develop the acute pathway. Compliance with the 4-hour standard has reduced in June and July, but we anticipate that August performance will have improved

Actions and Owners

Progression of new service model, including trialling of new Code Stroke EU pathway from June, review of triage processes, scoping for a new TIA clinic.

Revised breach analysis meeting with new membership across EU, radiology, service and site management

Ongoing QI work with Welsh Ambulance, including move to Prehospital Video Triage this year as part of phase 2 of the All Wales project

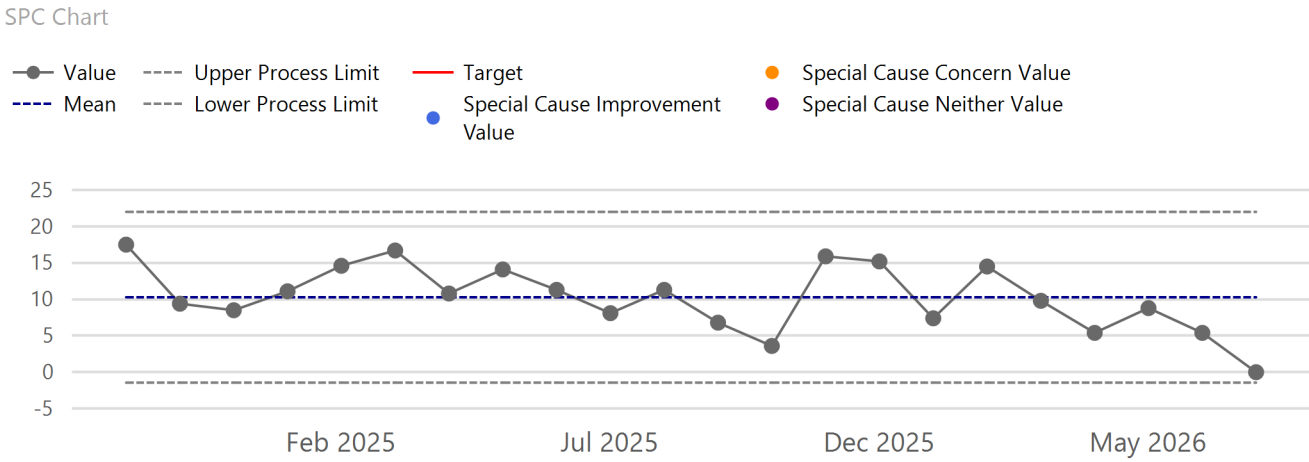
Education plan for all staff involved in stroke pathway being developed

Concerns

Reduced compliance with the new SSNAP standards

Metric ID: 10000137 % of stroke attendances that achieve CT Scan within 20 minutes

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	0				Chief Operating Officer



Narrative

Following the launch of the new SNNAP standards, the performance standard for CT scan has changed to 20 minutes. While performance against the old 60 minute standards averages over 50%, performance against the 20 minute standard has fluctuated between 3 and 17%. Performance against this metric is impacted by pressure in EU, periods of downtime for the CT scanner and the volume of self presenting patients who enter EU through triage. Actions relating to WAST, pre-hospital triage and early identification of self presenting patients are particularly pertinent to this measure

Actions and Owners

Progression of new service model, including trialling of new Code Stroke EU pathway from June, review of triage processes, scoping for a new TIA clinic.

Revised breach analysis meeting with new membership across EU, radiology, service and site management

Ongoing QI work with Welsh Ambulance, including move to Prehospital Video Triage this year as part of phase 2 of the All Wales project

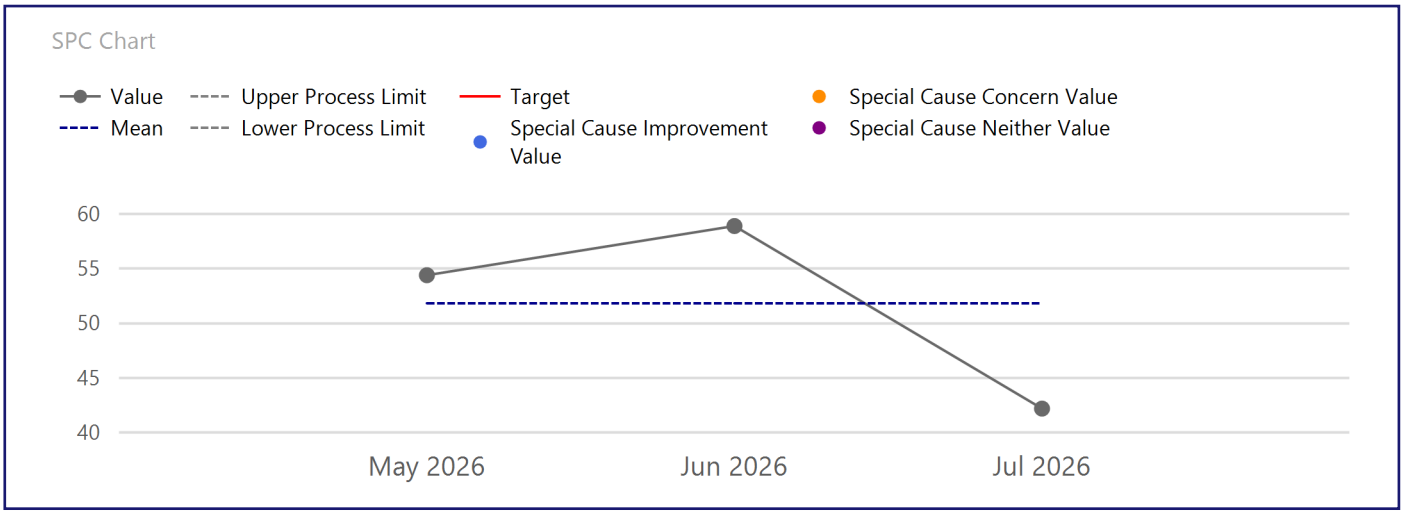
Education plan for all staff involved in stroke pathway being developed

Concerns

Reduced compliance with the new SSNAP standards

Metric ID: 10000138 % of stroke attendances that achieve CT Scan within 60 minutes

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	42.2				Chief Operating Officer



Narrative

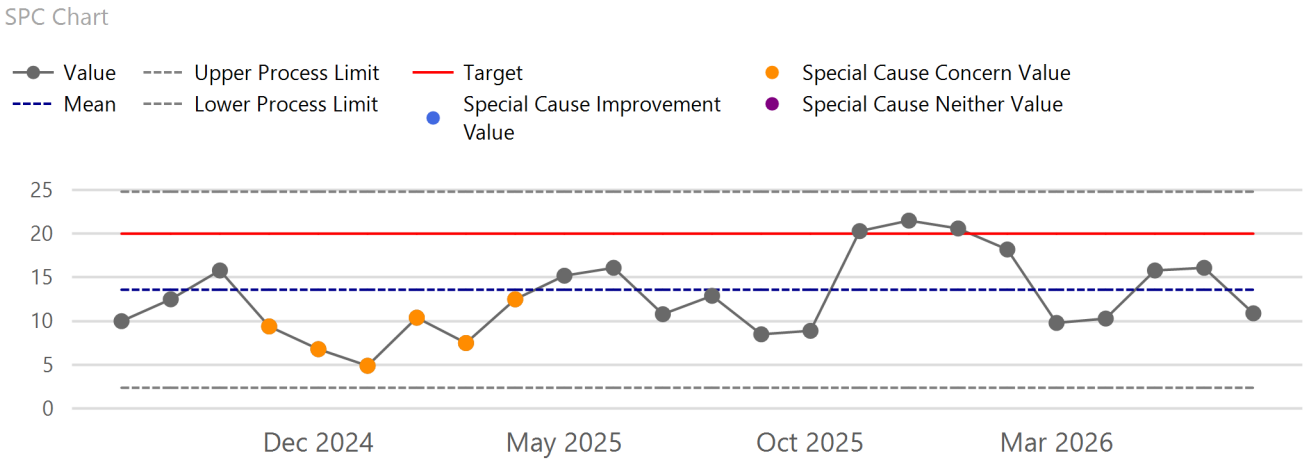
Uploaded data DRAFT not signed off

Actions and Owners

Concerns

Metric ID: 10000139 % of stroke patients who receive thrombolysis

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	10.9	20			Chief Operating Officer



Narrative

Standard of 20% was met in Q3 25/26 but compliance has dropped this year and remains below standard but in-line with the all-Wales and SSNAP average. Focused efforts through the last year, including the use of advanced imaging software and ongoing education have seen a meaningful increase in thrombolysis rates. Thrombolysis rates through the national reporting are sometimes lower as we wait from records related to regional and out of hours working to be processed

Actions and Owners

Progression of new service model, including trialling of new Code Stroke EU pathway from June, review of triage processes, scoping for a new TIA clinic.

Revised breach analysis meeting with new membership across EU, radiology, service and site management

Ongoing QI work with Welsh Ambulance, including move to Prehospital Video Triage this year as part of phase 2 of the All Wales project

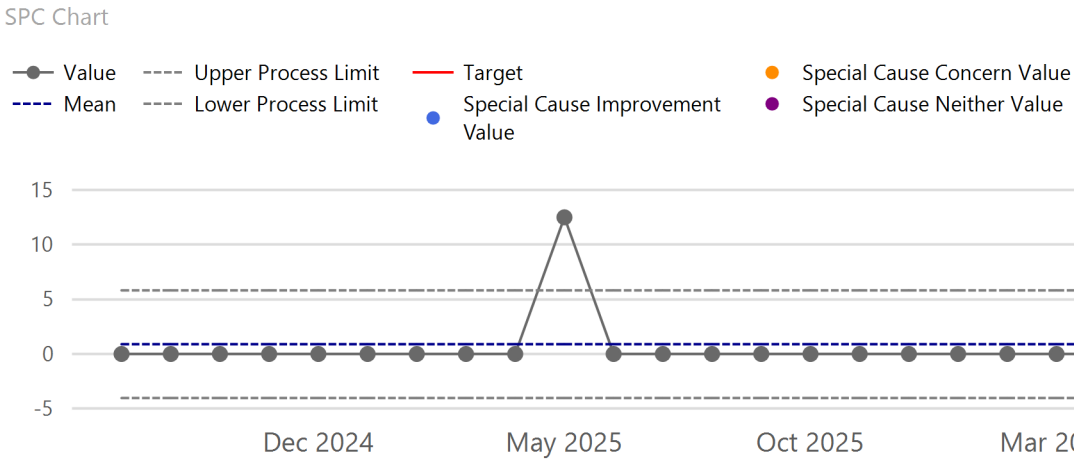
Education plan for all staff involved in stroke pathway being developed

Concerns

Reduced compliance with the new SSNAP standards

Metric ID: 10000140 % of stroke patients who receive thrombolysis within 30 minutes of attendance

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	0				Chief Operating Officer



Narrative

Door to needle thrombolysis treatment times remain a challenge and outside of the 30-minutes standard. All thrombolysis cases are reviewed by the stroke team and delay reasons investigated

Actions and Owners

Progression of new service model, including trialling of new Code Stroke EU pathway from June, review of triage processes, scoping for a new TIA clinic.

Revised breach analysis meeting with new membership across EU, radiology, service and site management

Ongoing QI work with Welsh Ambulance, including move to Prehospital Video Triage this year as part of phase 2 of the All Wales project

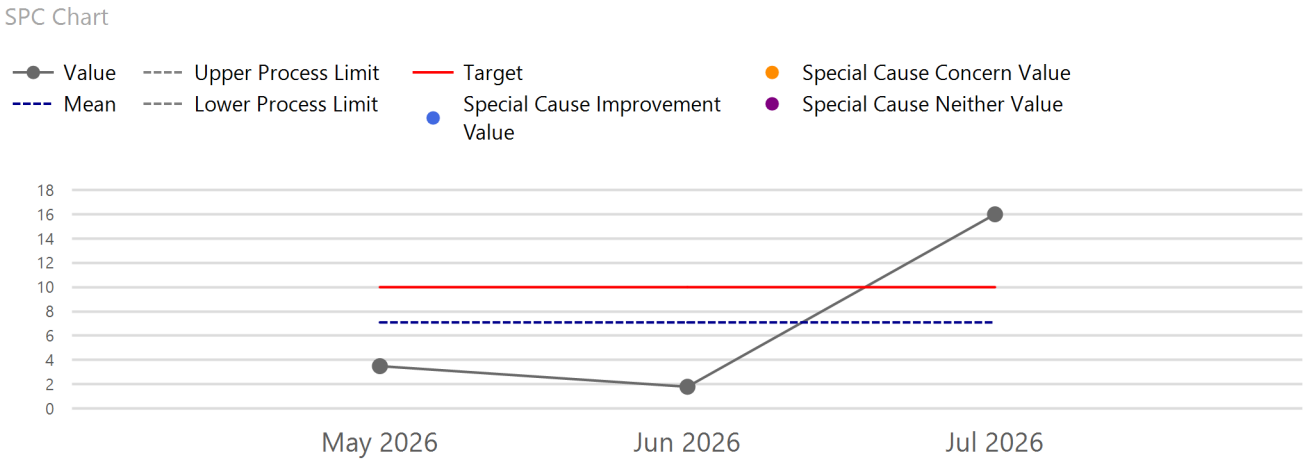
Education plan for all staff involved in stroke pathway being developed

Concerns

Door to needle time remains above standard

Metric ID: 10000141 % of stroke patients who receive thrombectomy

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	16	10			Chief Operating Officer



Narrative

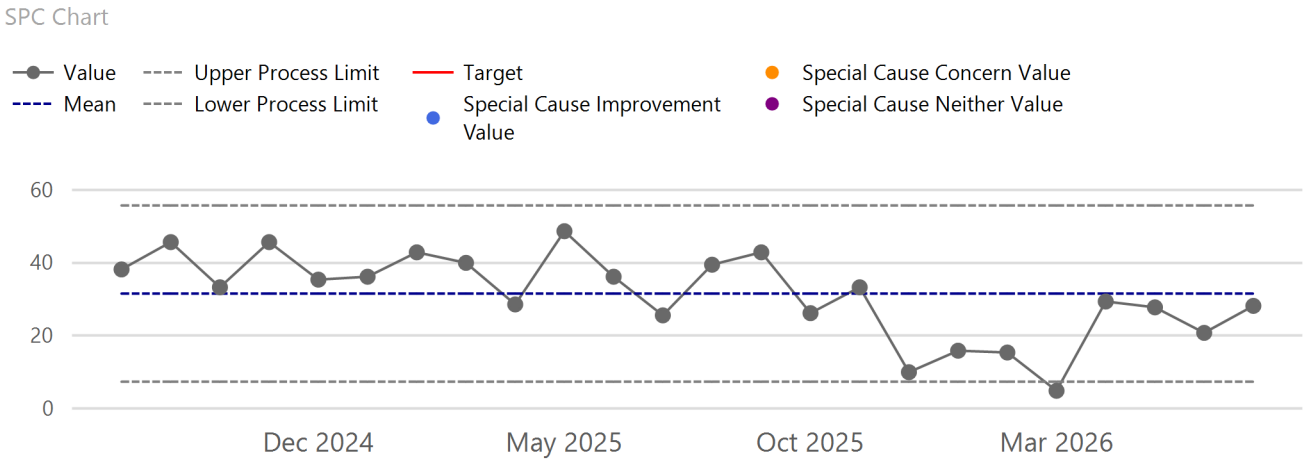
Uploaded data DRAFT not signed off

Actions and Owners

Concerns

Metric ID: 10000142 % of hip fracture admissions within 4 hours of arrival

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	28.2				Chief Operating Officer



Narrative

Recent performance and annualised average remain well above the national average on the National Hip Fracture Database

Actions and Owners

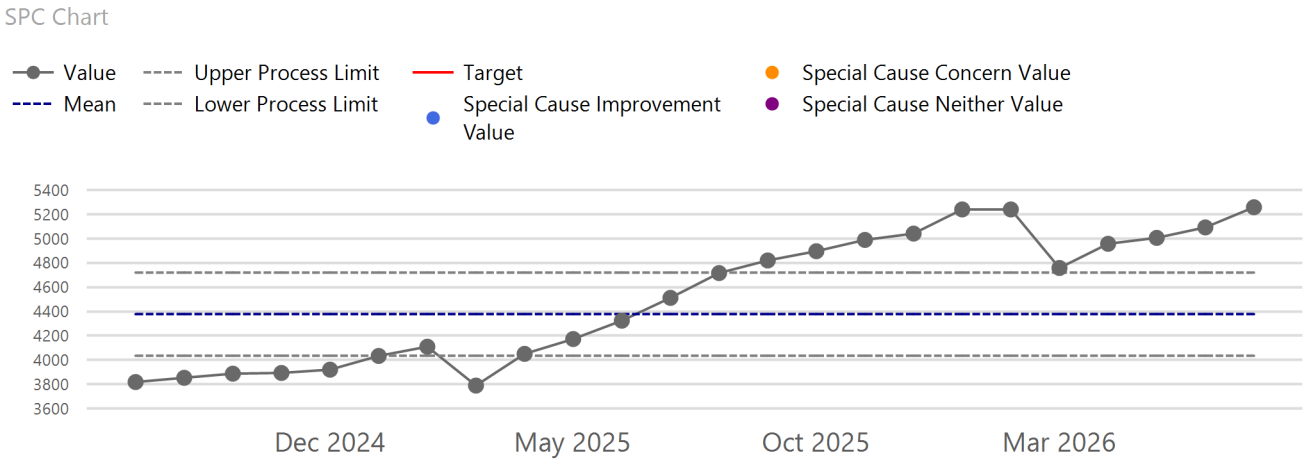
Ringfenced capacity remains
Review into Length of Stay
Morality review through Q&S

Concerns

Fluctuations in performance

Metric ID: 10000145 Volume of children waiting for neurodevelopment assessment - total

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	5258				Chief Operating Officer



Narrative

Performance remains consistently under the standard with capacity unable to match increasing demand for assessments. Despite this, a large amount of work has been undertaken over the past 2 years to transform the referral pathway, to reduce waiting times and support children and families waiting for assessment. These actions include:
-Referral pack includes clearer guidance and signposting pathway to support families while they are on the waiting list and reduce the risk of deterioration in the child's presentation
-Holistic approach across the ND pathway from referral. Whole-system approach has been embedded from triage through to full ND assessment - referrals are accepted for general neurodevelopmental concerns, with structured investigation into ASD, ADHD, and potential comorbidities at all stages to avoid repeat referrals.
-Development of an informed pathway for those children that at the time of the referral have already received input from different professionals and present clear features of ND conditions, to avoid to put them in the waitlist. These children will be given an outcome following a direct clinical contact soon after the referral has been processed
-Dedicated assessment pathways for young people aged 17 and over
-Making every contact count - stronger collaboration has been established across all services. A unified observation template has been drafted and is currently being trialled in OT and SALT to ensure consistent identification and recording of ND traits. Promotes seamless cross-referral and co-working between services

Actions and Owners

Non-recurrent money available for this year - currently assessing options for best use of this money within funding constraints. Additional actions to increase efficiencies and capacity:
Review of Consultant and Practitioner job planning to increase capacity by over 200 appointments/year
Clinical validation and new 'touch base' letters to allow those no longer needing the service to opt-out
Embed under 5s assessment protocol with dedicated SLT case note reviews. Reduced but does not remove requirement for 2nd assessment
Increased digitisation, including digital platforms for assessments and follow-up appointments
Continued engagement with Education

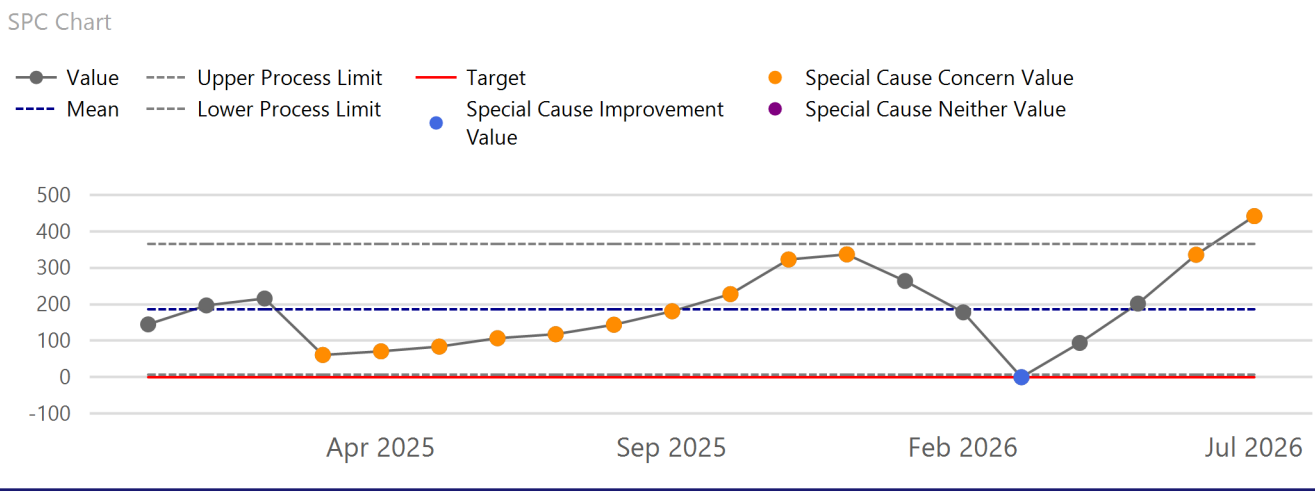
Performance is monitored within the Clinical Board and through the Clinical Board Executive Reviews

Concerns

Significant capacity shortfall under current model

Metric ID: 10000146 Volume of children waiting for neurodevelopment assessment - >156 weeks

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	442	0	F	H	Chief Operating Officer



Narrative

Performance remains consistently under the standard with capacity unable to match increasing demand for assessments. Despite this, a large amount of work has been undertaken over the past 2 years to transform the referral pathway, to reduce waiting times and support children and families waiting for assessment. These actions include:
-Referral pack includes clearer guidance and signposting pathway to support families while they are on the waiting list and reduce the risk of deterioration in the child's presentation
-Holistic approach across the ND pathway from referral. Whole-system approach has been embedded from triage through to full ND assessment - referrals are accepted for general neurodevelopmental concerns, with structured investigation into ASD, ADHD, and potential comorbidities at all stages to avoid repeat referrals.
-Development of an informed pathway for those children that at the time of the referral have already received input from different professionals and present clear features of ND conditions, to avoid to put them in the waitlist. These children will be given an outcome following a direct clinical contact soon after the referral has been processed
-Dedicated assessment pathways for young people aged 17 and over
-Making every contact count - stronger collaboration has been established across all services. A unified observation template has been drafted and is currently being trialled in OT and SALT to ensure consistent identification and recording of ND traits. Promotes seamless cross-referral and co-working between services

Actions and Owners

Non-recurrent money available for this year - currently assessing options for best use of this money within funding constraints. Additional actions to increase efficiencies and capacity:
Review of Consultant and Practitioner job planning to increase capacity by over 200 appointments/year
Clinical validation and new 'touch base' letters to allow those no longer needing the service to opt-out
Embed under 5s assessment protocol with dedicated SLT case note reviews. Reduced but does not remove requirement for 2nd assessment
Increased digitisation, including digital platforms for assessments and follow-up appointments
Continued engagement with Education

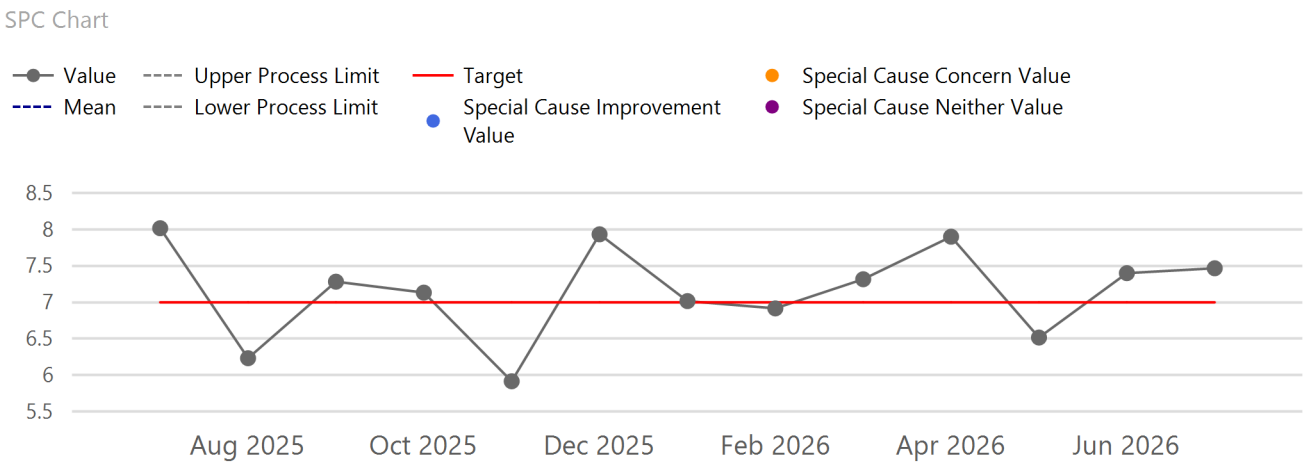
Performance is monitored within the Clinical Board and through the Clinical Board Executive Reviews

Concerns

Significant capacity shortfall under current model

Metric ID: 10000147 Median emergency ambulance response time to purple: arrest category calls

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	7.467	7	F		Chief Operating Officer



Narrative

This measure is owned by WAST. The C&V approach for reporting against these measures will be reviewed in Q3

Actions and Owners

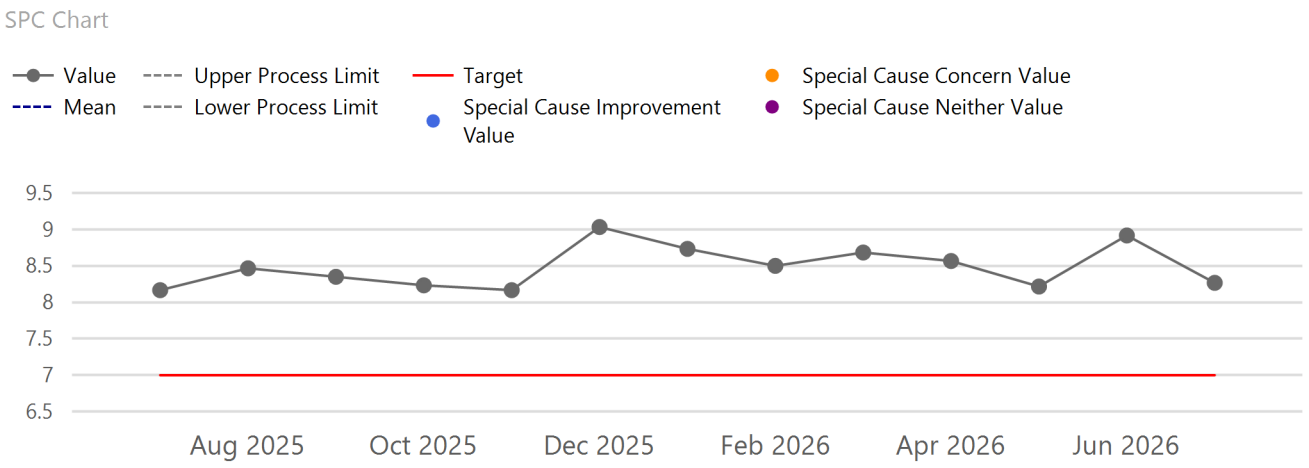
n/a

Concerns

n/a

Metric ID: 10000148 Median emergency ambulance response time to red: emergency category calls

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	8.267	7	F		Chief Operating Officer



Narrative

This measure is owned by WAST. The C&V approach for reporting against these measures will be reviewed in Q3

Actions and Owners

n/a

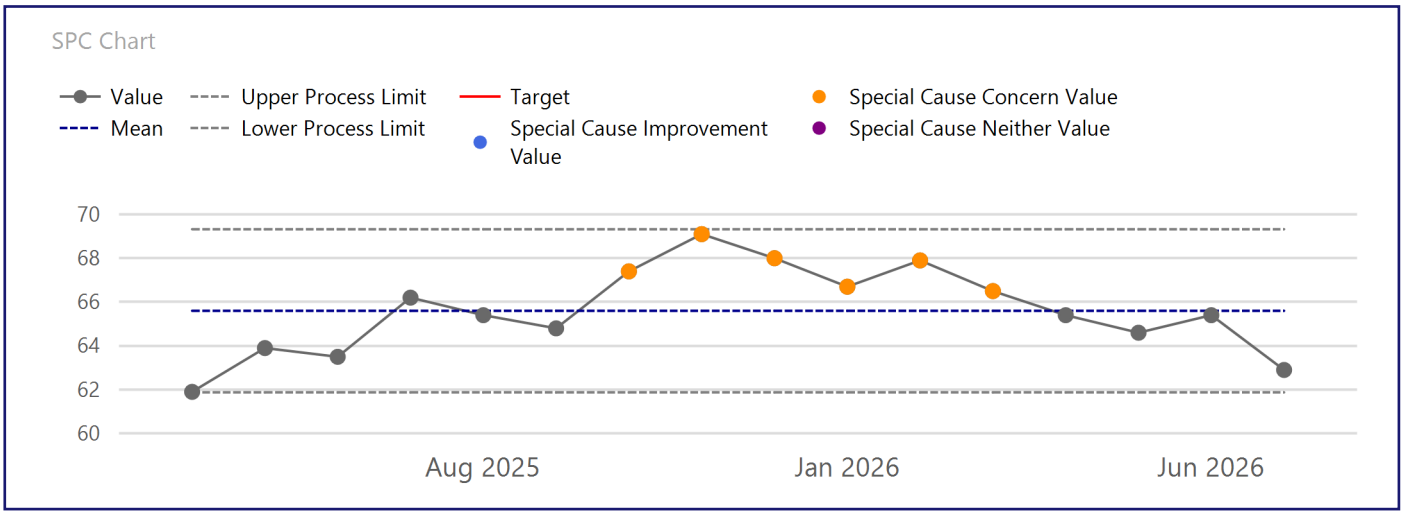
Concerns

n/a

Metric ID: 10000149

Percentage of R1 patient pathways, which have a target date allocated, waiting within their clinical target date or within 25% beyond their clinical target date for an outpatient appointment

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	62.9				Chief Operating Officer



Narrative

Consistent performance but not always meeting de-escalation requirement. The R1 cohort is predominantly made up of Glaucoma and Medical Retina Patients. We have gone live with our Glaucoma Diagnostic Unit which will allow us to see all our R1 Glaucoma patients in a timely manner.

Actions and Owners

Progressing business case to increase capacity for Medical Retina patients.

Working with Primary Care on pathway for Diabetic patients to reduce lower grade referrals and free capacity to see urgent patients in a more timely manner

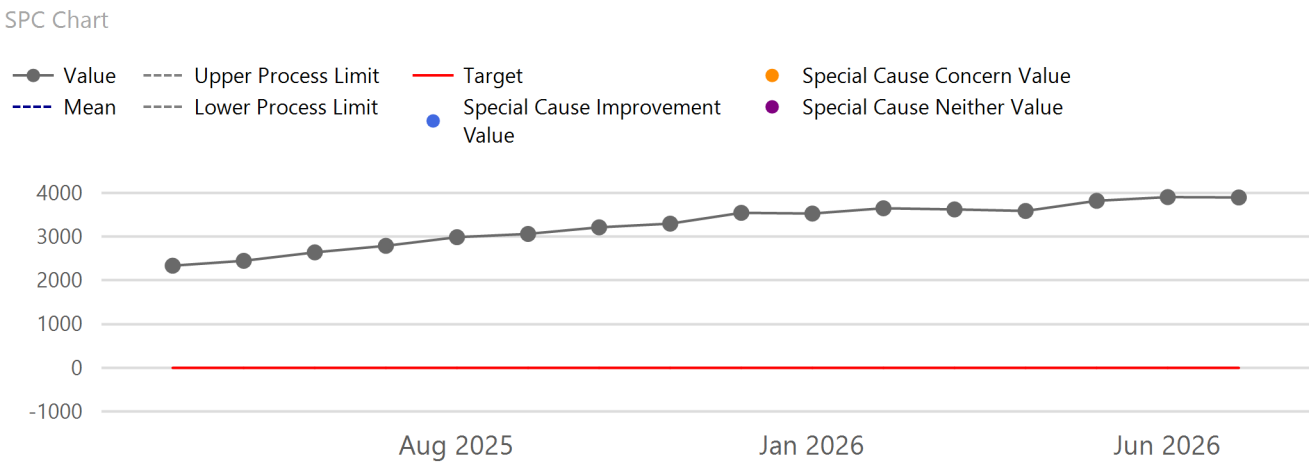
Concerns

Not consistently meeting de-escalation requirement

Metric ID: 10000150

Number of adults waiting more than 14 weeks for all audiology pathways (to include new and existing pathways for hearing aids, tinnitus and balance)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	3898	0	F		Chief Operating Officer



Narrative

We have seen an increase in the audiology waiting list through the last year driven by an increase in demand. 14 week waits have increased as capacity within the service is unable to match the increase. This has been observed in our neighbouring health boards with similar deterioration in 14-week performance. Clinical triage of referrals ensures urgent cases are identified and booked directly into the appropriate clinic.

Actions and Owners

Service are developing a text reminder service to reduce DNAs and validate patients who no longer need an appointment

3 audiologist posts recruited - starts dates in Q2 and Q3 - providing additional capacity

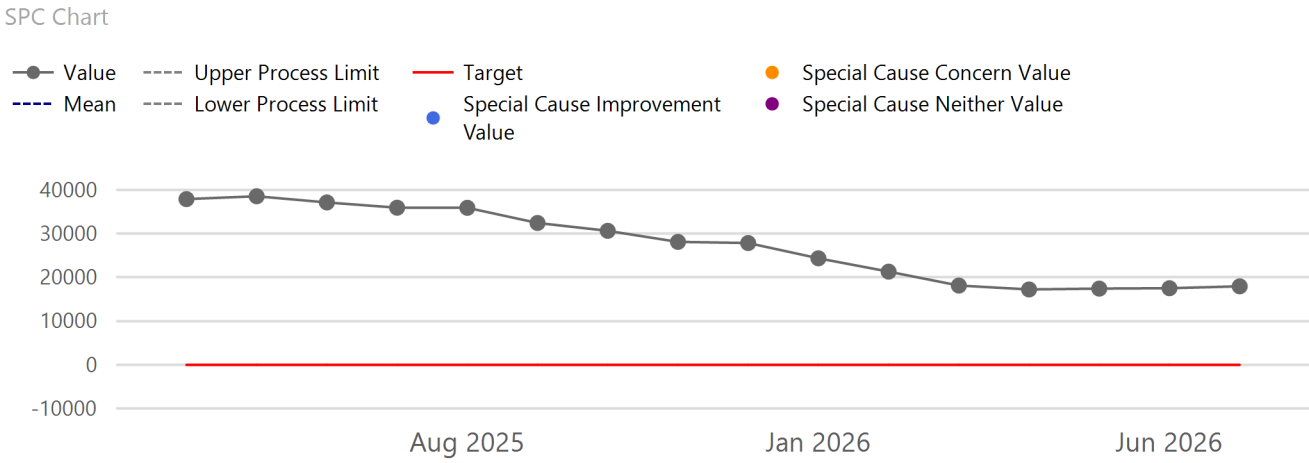
Concerns

Increasing demand and insufficient capacity to meet the waiting times standard

Metric ID: 10000151

Number of patients waiting more than 26 weeks for a new outpatient appointment

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	17973	0	F		Chief Operating Officer



Narrative

Significant reduction in the volume of long waiting outpatients through last year as a result of the National and Local outpatient insourcing work. An additional 22k appointments were delivered through the national scheme, with a further 9k through C&V schemes. This activity ceased in March 2026 and we have maintained this improved position.

The use of SPC charts in not appropriate for the RTT measures - the format for this reporting will be reviewed locally and in line with the national reporting dashboard

Actions and Owners

Outpatient improvement summit in July 2026.
From Q3 - overbooking of outpatient clinics to mitigate the impact of patient DNAs.

Focus on use of SOS/PIFU to free up follow-up capacity for new patients

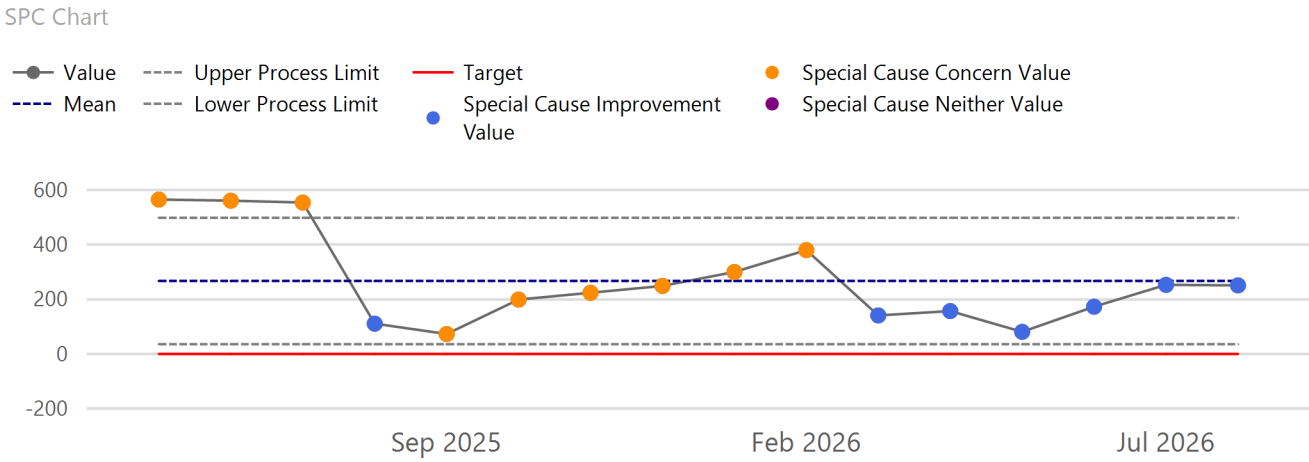
Actions and performance monitored through the newly established Executive Productivity and Efficiency Board

Concerns

Not meeting standard

Metric ID: 10000152 Number of ambulance patient handovers over 45 minutes

Latest Month	Value	Target	Assurance	Variation	Metric Owner
August 2026	251	0	F	L	Chief Operating Officer



Narrative

Our current performance remains improved from last year, but we see fluctuations in line with operational pressures in the EU and across the inpatient and assessment areas. In May 95% of handovers were completed within 45 minutes, this reduced to 88% in June and remained lower at 86% and 85% in July and August. We continue to focus on urgent and emergency care as we look to maintain this improvement with our ambition this year to maintain at least 95% of handovers within 45 minutes. All 45 minutes breaches are audited on a weekly basis. Welsh Government are currently reviewing the reporting criteria for Ambulance delays and we will reflect any changes to the methodology in our reporting

Actions and Owners

Suite of actions to support EU and flow:
Update and refresh of acute referral policy
Escalation triggers moved to 15 and 30 minutes
ACU desk to coordinate timely clinical responses
Acute physician pull model from ambulatory areas direct to Medical SDEC
Phase 1 of acute remodel - frailty assessment
Actions and performance metrics monitored through UEC Programme Board

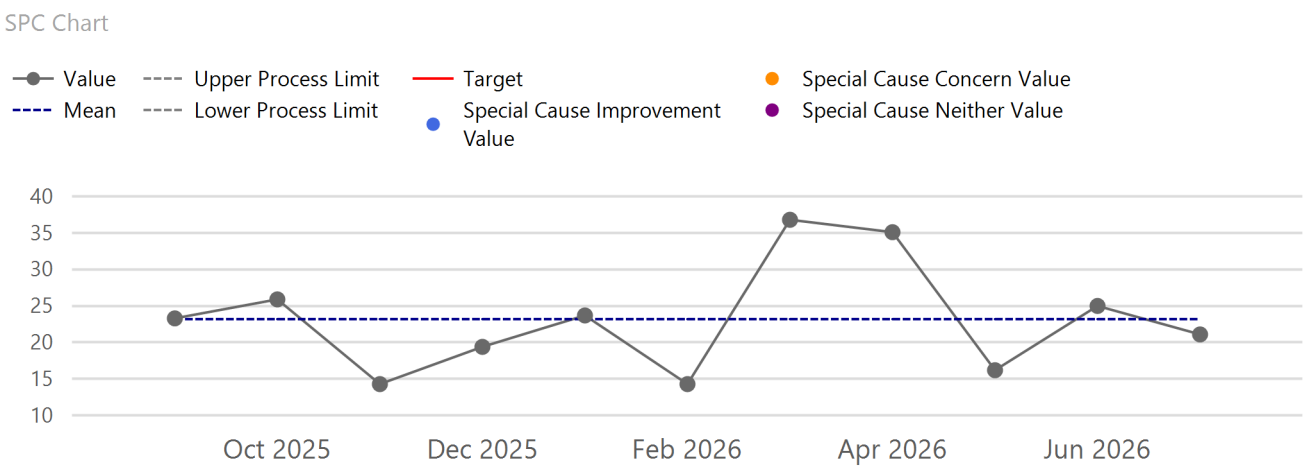
Concerns

Maintaining ambulance performance during periods of high escalation

Metric ID: 10000161

Percentage of people to have a heartbeat restored after a period of cardiac arrest which is subsequently retained until arrival at hospital (Return Of Spontaneous Circulation)

Latest Month	Value	Target	Assurance	Variation	Metric Owner
July 2026	21.1				Chief Operating Officer



Narrative

This measure is owned by WAST and the national data is currently under review. The C&V approach for reporting against these measures will be reviewed in Q3

Actions and Owners

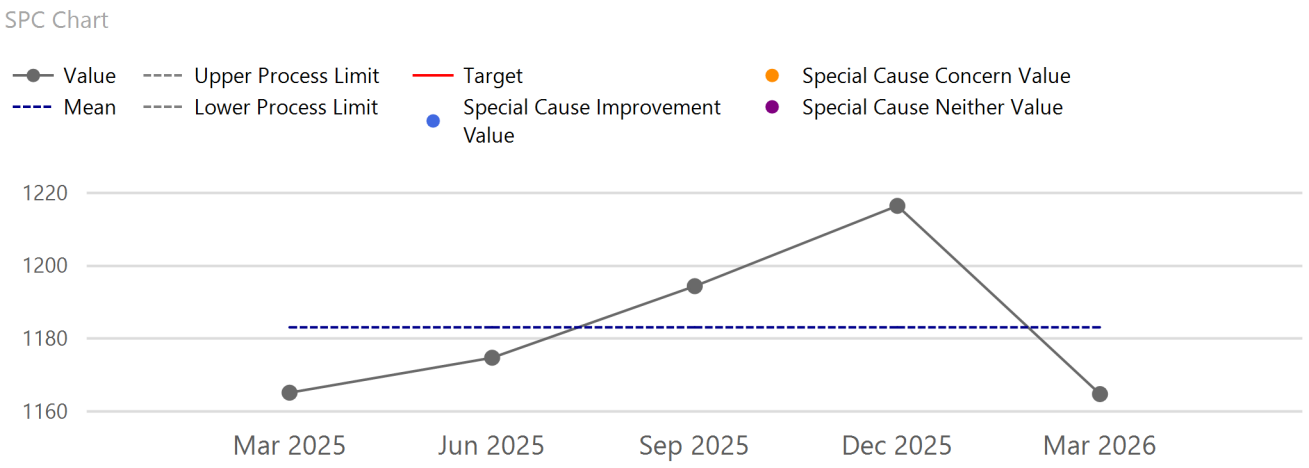
n/a

Concerns

n/a

Metric ID: 10000162 Gabapentin and pregabalin DDDs per 1,000 patients

Latest Month	Value	Target	Assurance	Variation	Metric Owner
March 2026	1164.82				Chief Operating Officer



Narrative

Currently the best performing health board in Wales, and below all NE England CCGs and the English average. The second-best performing HB is over 16% higher than CAV UHB.

Early proactive work to deviate from the trend early and avoided the scale of increased prescribing that other Health Boards experienced.

Various projects and education pieces have been undertaken over the last decade to promote appropriate prescribing to both primary care prescribers and specialist teams, agreeing and adherence to prescribing pathways and routes to deprescribing.

Actions and Owners

Focus remains on decreasing inappropriate prescribing and prescribing safely.

Project focussed on safe prescribing included in the 2026/27 Medicines Management Incentive Scheme for GP practices.

PCIC medicines management team to promote the All Wales gabapentinoid resources for chronic pain once published.

Concerns

Ability to decrease prescribing, when prescribing is already in the lowest quartile of all England and Wales areas, is difficult.

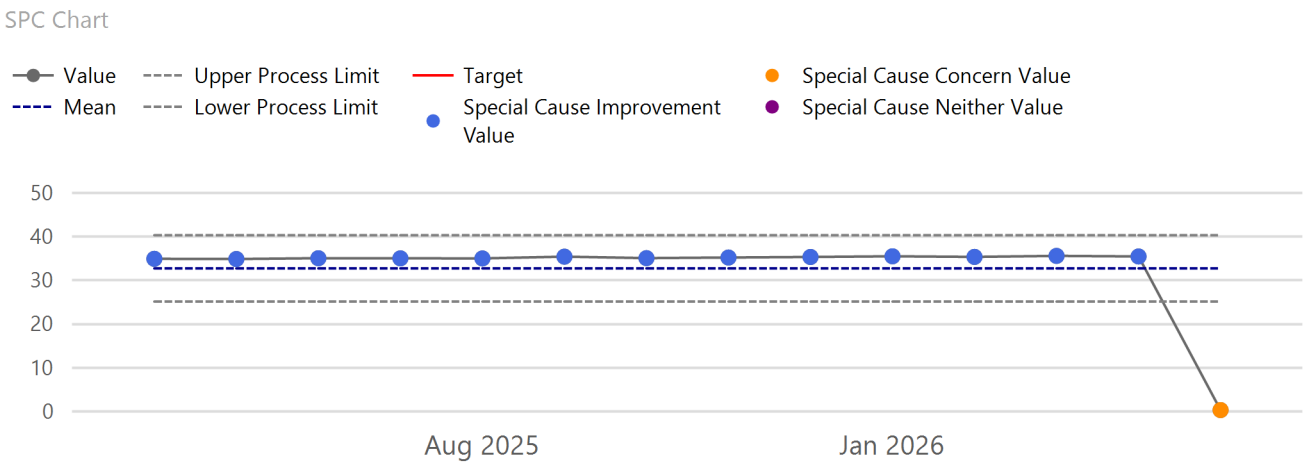
A drive to reduce gabapentinoid prescribing may cause an increase is other analgesia e.g. opioid prescribing, which may also pose safety concerns and be measured in other indicators.

Change takes time and relies on clinician and patient engagement and management of expectations.

Metric ID: 10000163

Average quantity per item prescribed from start period for the reference basket of medicines

Latest Month	Value	Target	Assurance	Variation	Metric Owner
May 2026	0.3582				Chief Operating Officer



Narrative

Currently the best performing health board in Wales, with the highest quantity per prescription item and the greatest percentage change from the start of data collection.

The only Health Board in Wales already above the prescribing interval target of 35 days (achieved June 2025).

The Welsh Government response to the Dispensing Volume Review (Jan 2022) and the All Wales Medicines Strategy Group guidance (October 2022) has been promoted to GP practices, Clusters and also with specialist teams within the wider UHB, when opportunity allowed. It has consistently been included in prescribing messages to GP practices at annual prescribing meetings, and engagement has been promoted via Community Pharmacy Collaboratives as well.

Actions and Owners

Continued promotion to GP practices.

A National Prescribing Intervals Short Life Working Group is currently meeting. Health Board actions from this group will be considered once published.

Concerns

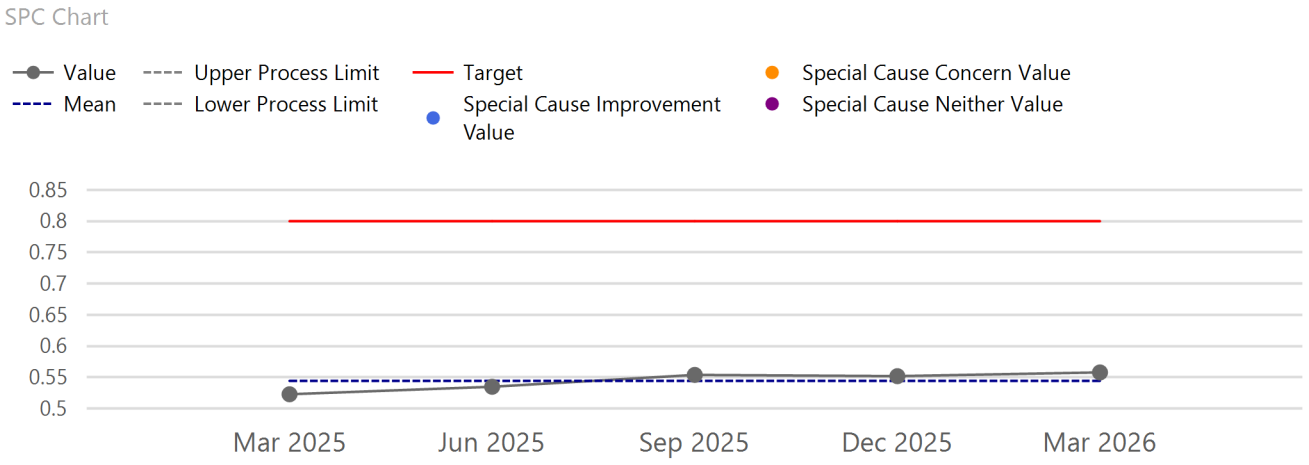
Implementation is limited by patient suitability for extended intervals of prescribing. Some patients and some medications are not suitable for this initiative.

Risk that promoting a fast pace of change will mean inappropriate patients are selected for this change which could lead to confusion, harm, increased waste along with increased workload and disengagement.

Metric ID: 10000164

Number of low Global Warming Potential (GWP) inhalers as a percentage of all inhalers prescribed

Latest Month	Value	Target	Assurance	Variation	Metric Owner
March 2026	0.558	0.8			Chief Operating Officer



Narrative

Currently the best performing health board in Wales, and above all NE England CCGs and the English average. Improvement continues.

Concerted work started in 2021/22 with heavy promotion of the All Wales Respiratory Guidance across all GP practice workforce, QI projects as part of the Medicines Management Incentive Scheme for GP practices as well as the PCIC medicines management team's work programme. In 2022/23 the Green Inhaler GMS QI project promoted the message further and learning from this project continues to embed.

Actions and Owners

Continued promotion of message to primary care workforce.

Identification and engagement with outliers.

Concerns

Change takes time given the volume of inhalers prescribed – some inhalers necessitate different technique which requires patient counselling.

Increasing amount of low carbon footprint inhalers are coming to market so indictor subject to change.

Risk that prescribing spend may increase as low carbon footprint inhalers are often more expensive.

Report Title:	Theatres Together Improvement Programme Progress Report				Agenda Item No:	6.12	
Meeting:	Board		Public	x	Meeting Date:	24.09.26	
			Private				
Status	Assurance	x	Approval		Information/Noting		
Lead Executive Title:	Chief Operating Officer						
Report Author Title:	Deputy Director of Nursing						

Main Report

Background and Current Situation:

The Theatres Together Improvement Programme was established to deliver the recommendations arising from service reviews whilst supporting sustainable improvements across perioperative services. The programme is being delivered through a structured tranche-based methodology comprising Foundation, Embedding Culture, High Impact, Progression and Transition workstreams. Robust governance arrangements remain in place, including Executive oversight, fortnightly Project Board meetings, weekly scrum meetings and dedicated task and finish groups.

The programme continues to demonstrate sustained and visible improvement across workforce, culture, quality, safety and operational performance. To date, 43 of the 66 recommendations have been successfully completed, 29 recommendations remain in progress and only 3 recommendations are yet to commence. The Foundation Tranche has been successfully completed, and subsequent tranches are now being delivered concurrently to accelerate improvement and maximise benefits realisation.

Significant achievements have included improvements to staff facilities and wellbeing, strengthened leadership visibility, implementation of workforce development initiatives, enhancements in communication and engagement, progression of quality and safety programmes and advancement of theatre productivity and efficiency workstreams. Improvements in data quality, accuracy and accessibility, supported through implementation of the Aqua theatre management system, have enabled the development of more objective and evidence-based plans in relation to theatre optimisation and utilisation. Enhanced data quality is providing greater visibility of performance, capacity and operational challenges, supporting more informed decision-making and targeted improvement activity.

Workforce sustainability remains a central focus of the programme. Workforce indicators continue to demonstrate favourable trends, including reduced sickness absence, lower staff turnover and improved appraisal compliance. These indicators provide objective evidence of a more stable, engaged and resilient workforce capable of supporting high-quality, safe and efficient patient care.

The Hospital Sterilisation and Decontamination Unit (HSDU) improvement programme has also been incorporated into Theatres Together governance arrangements, enabling enhanced support, oversight and accountability for delivery of improvement activity within the service.

Overall, the progress achieved to date provides assurance that the programme continues to improve patient safety, workforce experience, culture and operational effectiveness whilst creating the foundations for long-term sustainable change.

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

The Executive view is that the Theatres Together Programme continues to demonstrate strong progress and provides assurance that meaningful and sustainable improvements are being delivered across perioperative services. There is clear evidence of delivery against programme objectives, with improvements already embedded across workforce, culture, leadership, patient safety and operational effectiveness.

The programme has successfully moved beyond the delivery of immediate remedial actions and is now focused upon longer-term transformation, workforce sustainability, productivity improvement and the embedding of a positive organisational culture. Improvements are increasingly becoming

integrated into business-as-usual practice and are delivering measurable benefits for both staff and patients.

The Board is asked to note that whilst significant progress has been made, several strategic risks remain under active management. These include:

- Funding requirements associated with implementation and sustainability of recommendations requiring capital or revenue investment.
- Workforce and operational capacity constraints which may affect the pace of delivery of remaining actions.
- Risks relating to sustaining theatre productivity and efficiency improvements.
- Successful transition of recommendations and programme benefits into business-as-usual governance arrangements.
- Funding requirements associated with the standardisation of anaesthetic rooms across theatre services.

Comprehensive mitigation plans are in place and continue to be monitored through established governance arrangements. Executive oversight remains in place to ensure delivery momentum is maintained and that programme benefits are sustained beyond programme closure.

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

Theatres Together Improvement plan V1.5 10 September 2026 which includes:

- Programme Risk and issues (Appendix 1).
- Programme Governance Framework (Appendix 2).

This plan can be found in the supporting documents on the Cardiff and Vale UHB website (click to view) and for colleagues, it can be located in the supporting documents folder on the Board MS Teams Channel.

Recommendations:

. The Board is requested to:

a) Note the progress achieved through delivery of the Theatres Together Improvement Programme and the successful completion of the Foundation Tranche.
b) Receive assurance that effective governance, programme management and oversight arrangements remain in place to support delivery and management of programme risks.
c) Note the positive progress demonstrated across workforce, culture, quality, patient safety and theatre efficiency workstreams.
d) Note the strategic risks identified within the programme and the mitigating actions in place to support delivery and sustainability.
e) Support continued transition of programme outcomes into business-as-usual arrangements to ensure long-term sustainability of improvements.

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	x

Five Waves of Working (Sustainable Development Principles) considered: Please place an "x" in the below boxes where relevant									
Prevention	x	Long Term	x	Integration	x	Collaboration	x	Involvement	x

Quality Impact Assessment Completed? Please place an "x" in the below boxes where relevant					
Yes		No	x	The impact assessment is within the improvement document	

Impact Assessment Please place an "x" in the below boxes where relevant
Risk: Yes
Programme risks continue to be actively managed through the governance framework. Key risks include funding availability, workforce capacity, sustainability of improvements and delivery of theatre productivity and efficiency improvements.
Safety: Yes
The programme includes multiple patient safety initiatives including WHO checklist standardisation, quality assurance processes, equipment standardisation and strengthened governance arrangements.
Financial: Yes
Several recommendations require ongoing capital or revenue investment to support implementation and long-term sustainability. Funding requirements continue to be reviewed through established governance processes.
Workforce: Yes
The programme has significant workforce implications and benefits including leadership development, workforce planning, competency development, education programmes, recruitment, retention and wellbeing initiatives.
Legal: No
Reputational: Yes
Successful delivery of the programme supports organisational reputation through improvements in quality, safety, workforce engagement and operational effectiveness.
Socio Economic: Yes
Improved productivity, utilisation and patient flow support equitable and timely access to surgical services and contribute to reducing inequality of outcome for the population served by Cardiff and Vale UHB.
Equality & Health: No
This report provides an assurance update on programme progress. Any future service changes arising from recommendations will be subject to appropriate equality and health impact assessment processes.
Decarbonisation: Yes
Improved utilisation, reduction in waste, standardisation of equipment and more efficient service delivery contribute positively to sustainability objectives.
Welsh Language: No
The programme remains aligned to organisational commitments relating to Welsh Language Standards, equitable access and patient-centred care.

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:
Theatres Together project board	ongoing
Surgical Clinical Board Meetings	ongoing
Surgery Clinical Board QSE	ongoing

Report Title:	Dental Contract Reform 2026 – update on implementation, risks and mitigation				Agenda Item No:	6.13	
Meeting:	C&V Board Meeting		Public		Meeting Date:	24.09.26	
			Private				
Status	Assurance	X	Approval		Information/Noting		X
Lead Executive Title:	Chief Operating Officer						
Report Author Title:	Head of Operations (Primary Care), PCIC						

Main Report

Background and Current Situation:

The introduction of General Dental Contract Reform from April 2026 represents the most significant reform of NHS dentistry in Wales, since the general dental services contract was introduced in 2006 (which linked contract value to activity targets and incentivised regular six-month recalls for healthy patients). Existing contracts (retaining their current financial values) transferred automatically to the new arrangements.

The new contract arrangements introduced a new urgent care model, requiring practices to provide a defined number of urgent appointments for new patients each year (equivalent to approximately 12,000 patients in Cardiff and Vale). In addition, a central component is the introduction of the Dental Access Portal (DAP), the single national route for people seeking routine NHS dental care. To promote fairer and more equitable access, practices are required to obtain new NHS patients through the DAP rather than accepting patients directly. The new dental contract is structured into defined service segments (new patients, new urgent patients, care packages, prevention, recall). Each segment represents a proportion of the overall contract value. Practices are given percentage targets for each segment, which together make up 100% of their total contract value.

This paper provides an interim update since Dental Contract Reform was implemented. It also highlights some of the issues, risks and actions being taken.

Contract Terminations and re-procurement

Prior to the commencement of the new arrangements, **8 contracts were handed back and one contract had activity reduced.** The value of these equate to **£825,000 (3% of the total annual contract value)** and displacing around **7,000 patients**. To mitigate the impact on access to NHS dentistry, a re-tender process is underway (live on 21 September). Approximately half (£400k) of the total available dental activity funding will be tendered in four lots. The allocation will prioritise locations where there is both high patient demand and confirmed capacity from dental providers to take on additional patients, thereby maximising access and service impact. This process is expected to be completed by January 2027.

£150K of the available funding from the contract handbacks will be held in reserve until the completion of mid-year contract reviews. This will allow for a more informed assessment of practice performance against contractual targets and provide flexibility to reallocate funding where there are identified gaps, over-performance, or emerging pressures.

There will also be a review of the three orthodontic providers to assess demand and capacity and identify any risks to service delivery and patient outcomes, with subsequent decisions about allocating any additional orthodontic resource.

It is positive to note that there have been no further terminations since 1 April and currently there are 56 dental contracts across Cardiff & Vale.

Dental Funding 2026-27

Welsh Government has recently written to all Health Boards setting out the expectation that Health Boards utilise their full dental allocation to support the delivery of NHS dental services. **Any unspent funding forecast at Q3 will be recovered by Welsh Government**. This will enable sufficient time for the new contract to embed and for any

associated procurement to be undertaken. To note it will be an in-year adjustment only and there will not be a reduction in the allocation for 2027-28

Dental Access Portal and New Patients

Under the new contract arrangements, patients are no longer able to directly approach NHS dental practices for care. Unless they choose to access services on a private basis, patients are required to register on the Dental Access Portal (DAP). It is really positive that **more than 17,000 patients have been allocated** to local dental practices since April (over 3 phases), with a further phase planned before the end of 2026. It is projected that around **24,000 patients will be allocated to local dental practices during 2026/27**.

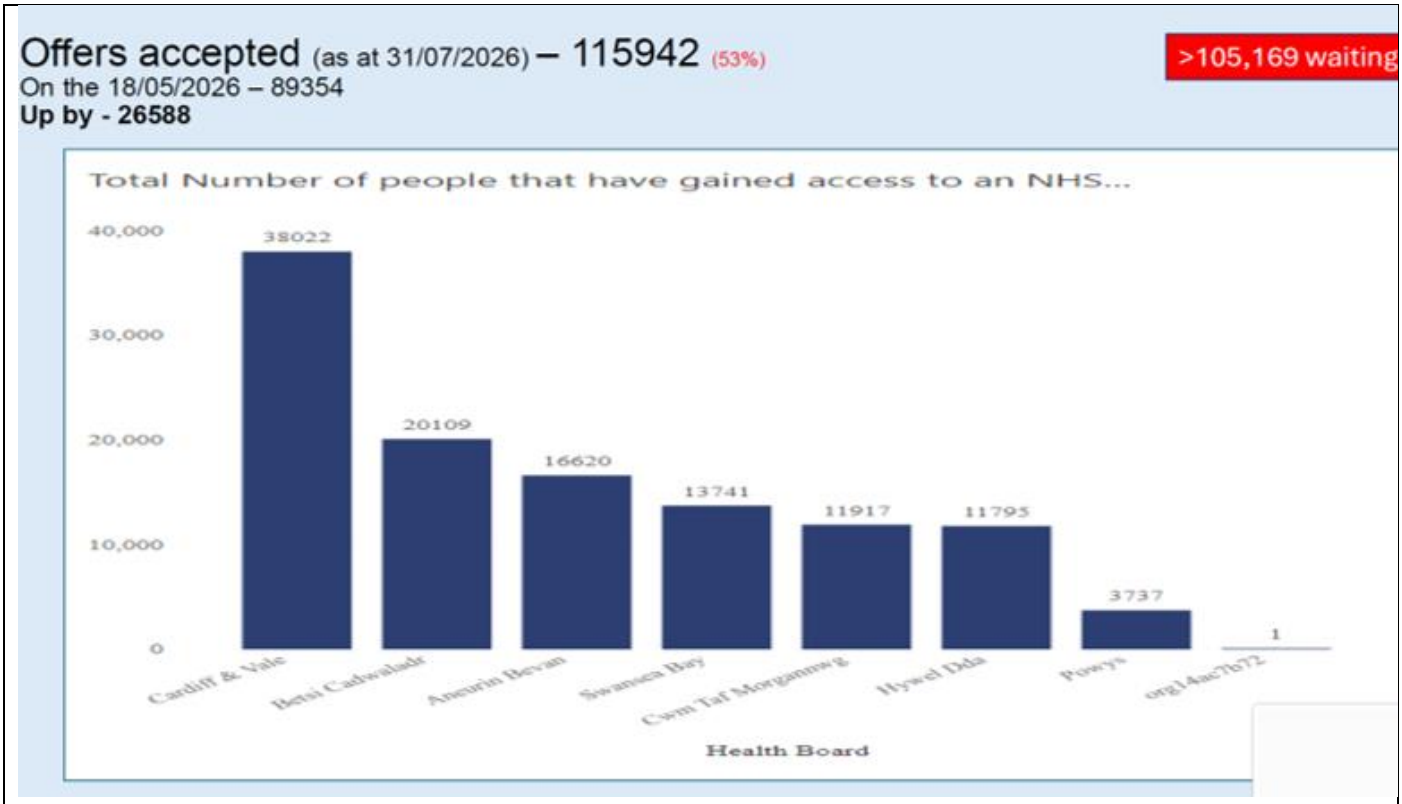
There are currently approximately **7,070 patients registered on the DAP** (610 of those are under 18 years**)**, with around **1,800 additional patients joining each month**. Waiting times have improved since May 2026. The wait for adults to be allocated to a dentist has reduced from 15 months to 7 months, and for children the wait is now 2 months**.**

The Health Board has also developed local media messages to promote the DAP on patient facing media platforms and with other primary care providers. There is also the intention for a national campaign by Welsh Government.

Data provided by Welsh Government shows the numbers of patients in Wales recorded on the DAP since it started in February 2025. It can be seen that Cardiff and Vale UHB has the second highest number of patients on the DAP but has the highest number of patients that have gained access to a dentist.

Dental Access Portal (as at 31/07/2026)
19th May 2026 – 189,817

Dental Access Portal Patient Table								
Source of patient record	PTHB	CAV	HDD	CTM	BCUHB	ABB	SBU	Totals
Bulk uploaded from legacy list	3460	18295	12146	4905	18	91	73	38988
New records created by patients	6471	23728	19682	23029	47462	28344	23722	172438 78%
Created manually by HB staff	1611	1150	2512	1146	775	578	1913	9685 4%
Totals	11542	43173	34340	29080	48255	29013	25708	**221111**



New Contract Segmentation and Mid-Year Review

Several contractors have shared concerns about how contract segmentation works in practice. Without previous experience of this model, it is difficult for them to predict how to apportion work and assess how quickly they will reach the targets. There are concerns regarding the care package element, which comprises of nine packages of care with varying values. Although a significant proportion of funding sits within this area (83.5%), practices cannot predict the mix of care packages required. This creates a risk that allocated funding could be exhausted earlier than anticipated, potentially resulting in patients having to wait until the next financial year for treatment. However, the Health Board may depart from the standard proportions within the 100% total if it is satisfied there are different levels of need in its area requiring adjustment to ensure patients are "properly provided for". The mid-year contractual review at month 7 will provide a better indication of how contractors will fulfil their contract for the remainder of the year. At this point, the Health Board has an opportunity to alter the segmentation values to meet local requirements and ensure patients' needs are met.

There have also been some issues raised with the data reliability of the claims reporting system which means there is not an accurate assessment of activity. This is a national issue. The primary care team is monitoring data on a monthly basis and is working with practices to review and re-submit claims as necessary. Due to some claims being rejected it is likely that the current activity is an underestimate of the actual position and we will take mitigations into account as part of the mid-year review.

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

- 56 General Dental Contracts transferred to General Dental Contract Reform from April 2026 and there have been no more contract terminations.
- It is positive that more than 17,000 patients have been allocated a dentist having been on the Dental Access Portal. There has also been a reduction in waiting times.
- A tendering process in being undertaken to re-provide capacity from the contract terminations and will focus on areas with highest need.
- There have been some challenges to monitoring activity due to issues around the reliability of claims data.

- A mid-year monitoring review will be completed by the end of October and will determine whether the Health Board needs to make any changes to the contract delivery segmentations to meet the needs of the population
- Welsh Government has confirmed that any unspent allocation will be recovered this year however it will not result in a reduction to the budget for 2027/28.

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

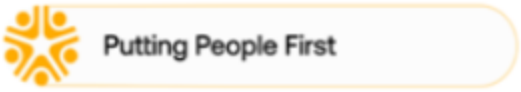
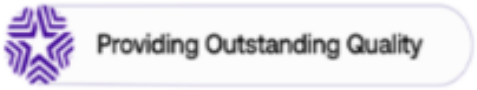
None

Recommendations:

The Board is asked to:

- Note the progress and position to date in relation to the implementation of Dental Contract Reform.

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. 	X	2. 	X
3. 	X	4. 	

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

Prevention	x	Long Term	x	Integration		Collaboration	x	Involvement	

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

Yes *(please include the complete QIA document)*		No *(please provide reasoning e.g. not required*	X	Not required

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

Risk: X

Addressed in the report. ***Contract hand-backs because of the new contract framework have the potential to reduce access to and destabilise dental services. There have been no further hand-backs since the start of the new arrangements. Arrangements are in place to commission services in areas of highest need.***

Safety:

Financial: X

Addressed in the report. ***There are financial implications relating to contract hand-backs (and the need to re-tender) as well as uncertainty about practices' ability to achieve the new contractual metrics and reliability of data. Activity freed up from contracts handed back are being reprovided through re-procurement of contracts, a robust contract assurance framework and review of the segmentation metrics will be undertaken at mid-year to ensure the budget is effectively utilised to ensure good access.***

It should be noted that it is Welsh Government's intention to recover any unused funding at quarter 3.

Workforce:

Legal: X
Where applicable the Health Board has worked within the direction given by the Welsh Government and relevant legal and operational contractual frameworks.
Reputational: X
It had been envisaged that the consequences of the contract reform would increase patient concerns in relation to less frequent check-up periods, and long waits on the Dental Access Portal. The scale of such concerns has not materialised. Neither have there been any issues concerning the understanding of the new charging and access arrangements leading to complaints and political escalation to the Health Board rather than Welsh Government.
-
Socio Economic: Yes/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*
There is potential for a positive outcome here, with more new patients able to access dental services, including those from more socio-economically deprived areas.
Equality & Health: X
Dental Contract Reform 2026 will lead to a redistribution of dental services, and the tendering of activity associated with contracts that have been returned, focuses in areas of greater dental need which results in a more equitable service.
Decarbonisation:
Welsh Language: X
Independent contractors are required to comply with the Welsh Language Duties as part of contractual arrangements with independent contractors. Bilingual patient communication has been produced by Welsh Government on the changes to general dental services and the Dental Access Portal.

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

Report Title:	Oversight of Access and Waiting Times in Primary and Community Care				Agenda Item No:	6.14	
Meeting:	C&V Board Meeting		Public		Meeting Date:	24.09.26	
			Private				
Status	Assurance	X	Approval		Information/Noting		X
Lead Executive Title:	Chief Operating Officer						
Report Author Title:	Assistant Director for Primary Care PCIC Deputy Director of Operations PCIC						

Main Report

Background and Current Situation:

Following consideration of feedback received from Llais on access to Primary and Community Care services, the Board sought assurance regarding the effectiveness of the existing oversight and governance arrangements. This report summarises the arrangements in place to monitor access and waiting times, relevant contractual and performance standards, concerns and complaints management, and actions to improve patient communication.

Primary Care:

Primary Care services are delivered through nationally directed contracts and regulations to include General Medical Services (GMS), General Dental Services (GDS), Community Pharmacy and Optometry. These contractual and regulatory arrangements do not set out Referral to Treatment Time (RTT) targets. As a result, oversight is achieved through contractual assurance, performance monitoring, activity reporting, governance arrangements and patient feedback mechanisms.

Access Standards

Provider	Standard or Expectation	Detail
GMS	Standard	(a) have a telephone system with a recording function for incoming and outgoing lines, that stack calls and allows for the analysis of call data, (b) have a telephone introduction message recorded bilingually in Welsh and English that in total lasts no longer than 2 minutes, (c) ensure that patients and care homes can order repeatable prescriptions digitally, (d) for the duration of core hours, ensure that patients can digitally request a non-urgent appointment or a call back, and that the necessary governance arrangements are in place for this process, (e) publicise information via the practice's online resource on— • the access requirements specified in this paragraph 4, and how patients can— • access the contractor's services, and • request an urgent, routine and advanced consultation, (f) offer a same day consultation for— • children under 16 with acute presentations, and • patients clinically triaged as requiring an urgent assessment, (g) offer pre-bookable appointments to take place during core hours; and (h) actively signpost patients to appropriate services— • available from the members of the contractor's cluster, • provided or commissioned by the Local Health Board, or • available locally or nationally.
General Dental Services	Expectation	Already a patient at an NHS dental practice – Patients are able to call them direct for any routine or emergency dental appointments If patients don't have an NHS Wales Dentist; • Urgent Dental Treatment is available via Emergency Dental Service • Able to apply for a place via the Dental Access Portal

Optometry	Expectation	For patients who have an eye problem that needs urgent attention - contact your local optometrist (optician) directly. You can go to your usual practice or contact any high street optometrist offering NHS services. For patients who have urgent problems outside of core hours – contact NHS 111 Wales
Community Pharmacy	Standard	Community pharmacy access standards in Wales are governed by the national Clinical Community Pharmacy Service (CCPS) framework, requiring nearly all community pharmacies to provide a standardized bundle of accessible clinical care. **Common Ailments Service (CAS):** Patients can walk in or consult a pharmacist for a defined list of common illnesses instead of booking a GP appointment, with medications supplied free of charge from an agreed formulary **Core Bundled Offering:** Any pharmacy accredited for the CCPS must offer an integrated package including CAS, emergency medicines supply (EMS), emergency contraception (EC), and seasonal flu vaccinations **Consultation Facilities:** Consultations must take place in person within a dedicated, private consultation room that meets specified national design and confidentiality criteria **Service Availability Reporting:** Pharmacy contractors are strongly encouraged to log their daily service availability through the national NHS Wales Shared Services Partnership tool so patients and NHS services know when care is accessible.

The following information aims to provides a snapshot of the data available for each primary care provider.

General Medical Services

The Health Board receives assurance through the Welsh Government GMS Access Commitment, quarterly compliance returns, activity reporting and quality indicators. The framework requires practices to demonstrate that:

- Patients can access and contact the practice through appropriate channels.
- Requests are appropriately navigated to the most suitable clinician or service.
- Care is prioritised according to clinical need.
- Patients receive a timely assessment and response.
- Information regarding access arrangements is clear and readily available.

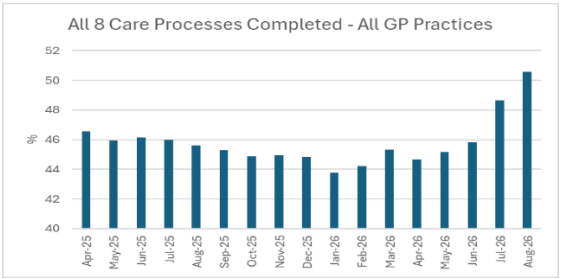
All Cardiff and Vale practices achieved 100% compliance with Welsh Government Access Standards during 2025/26.

The Health Board also monitors General Medical Services (GMS) activity to provide assurance on demand and service delivery within general practice. Although activity data does not directly measure access or waiting times, it demonstrates the volume of patient care delivered. It is reviewed alongside access standards, quality indicators and patient feedback to support oversight of service performance.



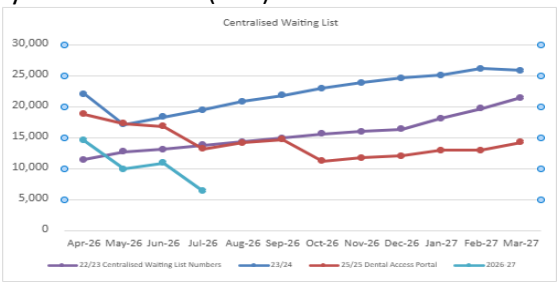


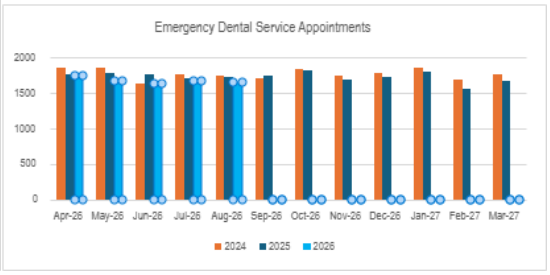
The Health Board gains assurance through clinical quality indicators, including the eight diabetes care processes, which support oversight of primary care quality and improved patient outcomes. Indicators are reviewed in line with Welsh Government requirements and local Health Board priorities.



General Dental Services

The Health Board monitors access to dental services through the Dental Access Portal (DAP) numbers, allocation of new patients and compliance with contractual national metric targets based on contract value. The graph below provides an overview of the number of patients waiting by year on the DAP. The Health Board also monitors demand for urgent dental care via the number of calls received and appointments provided via the Emergency Dental Service (EDS).



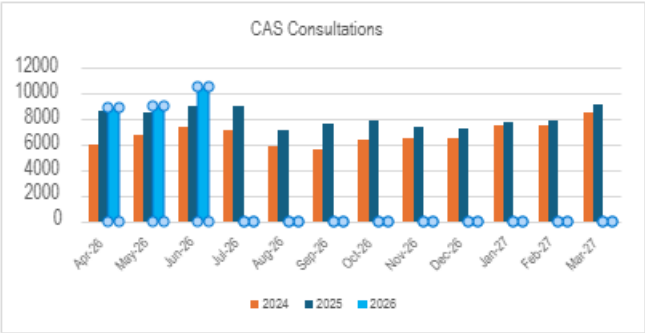


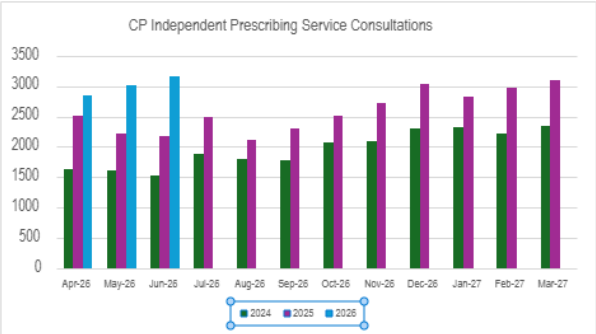
Following changes to the contract for managing urgent dental needs, patients may now be allocated directly to a dental practice for the relevant episode of care. This is expected to reduce the number of patients requiring emergency dental care delivered by the Health Board over time.

Community Pharmacy

The Health Board receives activity and service utilisation data for nationally commissioned Community Pharmacy services. This provides assurance on patient access and the contribution of community pharmacies to managing demand across Primary Care. The graphs below include activity delivered through the Common

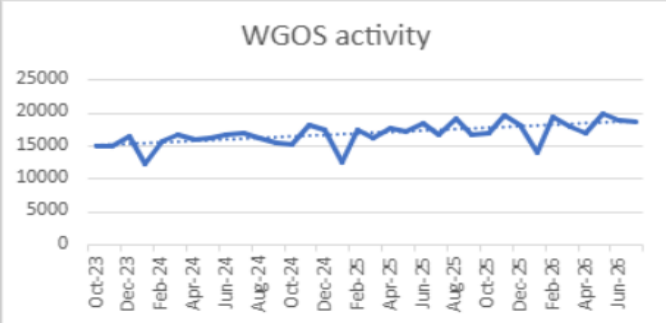
Ailments Service and Independent Prescribing, which enable patients to access advice and treatment for a range of minor conditions without requiring a GP appointment.

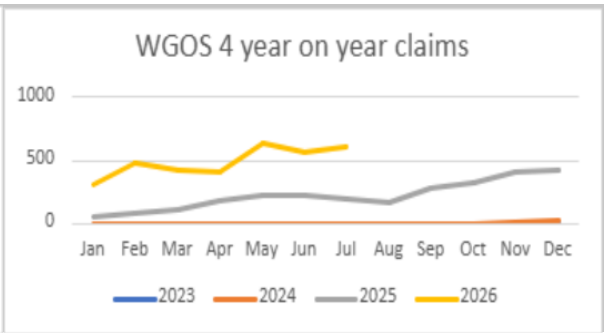




Optometry

Optometry services are monitored through Wales General Ophthalmic Services (WGOS) activity data, including routine eye examinations, urgent eye care assessments and community monitoring pathways designed to reduce demand on secondary care services. The graphs below provide an overview of all WGOS activity 105 combined as well as activity for WGOS 4 pathways.





GP Out of Hours Service

Patients with urgent medical needs that cannot safely wait until their GP practice reopens can access out-of-hours care through NHS 111 Wales, which connects them to the relevant Health Board service. The Health Board has limited influence over callback times while patients remain within the initial NHS 111 assessment process. Local targets remain based on clinical prioritisation of patients once passed to Health Boards for access to clinical triage, appointments and home visits.

Function	Standard	Activity/Performance Monitoring
Triage	Urgent (P1) – 60Mins Routine (P2) – 120Mins Routine (P3) – 240Mins	Daily, Weekly Monthly statistics are maintained and monitored. Monthly statistics are routinely shared with Welsh Government, Llais and Local Medical Committee (LMC)
Appointments	Urgent (P1) – 1 Hour Routine (P2) – 2 Hours Routine (P3) – 6 Hours	
Home Visits	Urgent (P1) – 1 Hour Routine (P2) – 2 Hours Routine (P3) – 6 Hours	

Community Services

Whilst Community services managed/delivered via PCIC Clinical Board are also not subject to RTT targets, these standards are used to guide waiting list management in applicable services.

Service	Waiting List Standard or Expectation	Detail
District Nursing	Community Nursing Specification guides response times	• Urgent (2-4hrs) • Non Urgent (72hrs) • Planned (10days)
Community Resource Teams (Cardiff/Vale)	Local Operating Protocol/SOP guides response times	• Urgent/routine referral response • 14 weeks used to monitor waiting list
Safe@Home	Local Operating Protocol/SOP guides response times	• 'Now' response to escalating needs • 48-72hour LoS
Acute Response Team (ART)	Local Operating Protocol/SOP guides response times	• Patient directed (e.g. IV antibiotic course)
Community Nursing (Bladder & Bowel, Wounds)	Community Nursing Specification guides response times	• As per Community Nursing Specification
HMP Cardiff	Partnership Agreement for Prison Health in Wales	• Access to services should be comparable to Primary/Community/Secondary care access standards/times
Department of Sexual Health, Incl. Local Gender Service	Local Service specification in line with Public Health surveillance/strategy (Women's Health Plan, HIV Action plan, etc)	• Urgent/routine referral response • 14 weeks used to monitor waiting list
Health Protection (Immunisation)	National Immunisation Framework for Wales/Vaccine Equity Strategy and/or specific policy direction	
CAVHIS	CAVHIS gives short-term help and health checks for people: • Who have moved to the UK from other countries seeking refuge or asylum • Who are homeless • Who have just come out of prison and meet certain eligibility criteria. • Gypsy, Roma and Traveller communities on unauthorised encampment sites. • People affected by sex work.	
End of Life	• Hospital, Community Palliative Care & Care Providers (Marie Curie, City Hospice) • End of Life Strategy & Clinical Protocols • RTT Standards followed for Hospital Palliative Care, including Community Follow Up	
Community Dental Services	The role of the Community Dental Service (WHC/2022/022)	• Statutory duty to provide dental services to meet all reasonable needs • patients who are accepted into the CDS for treatment often require more time to manage

For community services delivered directly by the Clinical Board, access and waiting times are monitored through service-specific waiting list reports, operational performance reviews and governance arrangements, with remedial actions implemented where performance concerns are identified.

Managing Concerns and keeping patients informed

Concerns and complaints received by the Health Board are reviewed by the Clinical Board Quality and Governance Team and allocated to the appropriate service for investigation. Themes, risks and learning are reviewed through service-specific Quality, Safety and Experience forums, where actions are agreed, monitored and reported through governance arrangements to ensure learning is embedded and service improvements are implemented. Escalation processes are in place where concerns indicate wider quality, safety or access issues

Between January and July 2026, the Clinical Board logged 93 entries relating to access and waiting times. Recorded themes included appointments, registration, waiting lists, delays, the Dental Access Portal (DAP), patient allocation and other access or waiting-time pathways, as summarised below.

Category	Number	Percentage
Concern	46	49.5%
Enquiry	41	44.1%
Other	6	6.5%
Total	93	100%

The highest volumes were recorded for Dental Team (52), Primary Care Team (13), GP Practices (13), DoSH (3), CAVHIS (2). Data relates only to concerns received by the Health Board and does not include concerns managed directly by independent contractor services.

Concerns and enquiries relating to Primary & Community Care services represent approximately 0.02% of the population served. The most common themes were:

- Enquiries about the Dental Access Portal
- Practice registration and boundary issues
- Appointment booking arrangements
- Queries about waiting lists or pathway delays

Limitations

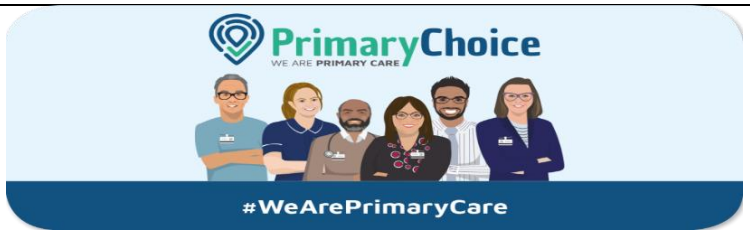
The Health Board can request contractual returns, activity, compliance and quality information, but does not have a contractual basis for routine RTT-style waiting time or real-time appointment availability data unless nationally specified. These limitations reflect both the contractual framework under which independent contractor services operate and the absence of a consistent national digital infrastructure capable of providing comparable real-time data across all providers. Much of the available data is extracted and collated nationally by Digital Health and Care Wales (DHCW) through the Primary Care Information Portal (PCIP) and is therefore subject to a reporting time lag rather than being available on a live basis.

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

While Primary and Community Care services are not subject to RTT performance targets in the same way as secondary care, the Health Board maintains oversight through contractual monitoring, access standards, activity data, quality indicators, patient feedback, concerns management and governance arrangements. Taken together, these provide assurance regarding access, demand and quality across Primary and Community Care services

Available performance information demonstrates compliance with Welsh Government GMS access requirements, routine oversight of activity and demand. Assurance is further strengthened through concerns and complaints monitoring and stakeholder engagement.

To improve public understanding of available services and access routes, the Health Board continues to deliver the Primary Choice campaign and provides information through websites, patient communications and social media channels.



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

N/A

Recommendations:

The Board is asked to:

- Note the arrangements in place to monitor and assure access across Primary and Community Care services.
- Note the performance information currently available to the Health Board and the associated assurance mechanisms.
- Note the limitations associated with the collection of waiting time data across independent contractor services.
- Note current activity relating to patient communication, concerns management and public engagement regarding access arrangements.

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	X

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

Prevention		Long Term		Integration		Collaboration		Involvement	

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

Yes *(please include the complete QIA document)*		No *(please provide reasoning e.g. not required*	X	Not required

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

Risk: X

Failure to maintain effective oversight of access arrangements may adversely impact patient experience, confidence and access to services. Existing governance, contractual assurance and performance monitoring arrangements mitigate these risks.

Safety: X

Effective access, navigation and prioritisation arrangements support timely clinical assessment and patient safety
Financial:
Workforce:
Legal: X
The Health Board operates within Welsh Government contractual frameworks and statutory requirements governing primary and community services.
Reputational: X
Poor patient experience regarding access has the potential to impact Health Board reputation. Oversight arrangements, complaints management and public communications assist in mitigating this risk
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: X
No Equality and Health Impact Assessment is required. However, equitable access remains a key principle underpinning all access arrangements and assurance processes
Decarbonisation:
Welsh Language: x
Information and communications relating to access arrangements are provided in accordance with Welsh Language Standards and contractual requirements placed upon independent contractors

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

Report Title:	Risk Management					Agenda Item No:	7.1
Meeting:	Board		Public	X		Meeting Date:	24 Sep 26
			Private				
Status	Assurance		Approval	X		Information/Noting	
Lead Executive Title:	Director of Corporate Governance						
Report Author Title:	Director of Corporate Governance						

Main Report
Background and Current Situation:

In the last year risk management in CVUHB has been interrogated by:

- 25/26 Structured Assessment by Audit Wales;
- Apr 26 Internal Audit report (Reasonable Assurance);
- Aug 26 Independent Assessment of CVUHB;
- throughout the escalation process.

The observations, actions or recommendations that have resulted are set out below.

	Source	**Observation/Action/Recommendation**
1	Audit Wales Structured Assessment Dec 25	While the Board receives the Corporate Risk Register (CRR) at each meeting, it is for information only and committee level oversight arrangements for corporate risks is still not clear.
2	Risk Management & Board Assurance Framework Internal Audit Apr 26	Risk Management Documentation - The Risk Management Policy, although recently updated for the introduction of AMaT contains some errors and inconsistencies, with links to supporting documentation that is out of date.
3	Risk Management & Board Assurance Framework Internal Audit Apr 26	Data Cleansing - The migration of risks onto the AMaT system is largely complete and some directorates have taken the opportunity to review the information recorded to ensure that it remains both current and relevant. However, other areas of the Health Board have not thus far taken this opportunity and with approximately 1500 risks on the system it is important that any out-of-date, irrelevant or duplicated information is removed where possible. We acknowledge that the Health Board are aware of this need and have set a deadline of the autumn of 2026 to achieve it.
4	Risk Management & Board Assurance Framework Internal Audit Apr 26	Clinical Board Executive Reviews - The evidence on the testing of the Executive Clinical Board Reviews was that whilst there were some references to risk, there appeared no consistency to the approach and very little tangible linking to formal risk registers. However, discussion with Risk Leads suggested that they are usually challenged on their key risks in these meetings. We are aware that the Health Board is currently reconsidering the structure and content of these reviews and having a formal and consistent slide on key risks for each Clinical Board would in our view be helpful.
5	Risk Management & Board Assurance Framework Internal Audit Apr 26	Corporate Risk Register - The Corporate Risk Register is reported to every meeting of the Board and contains all operational risks scoring 20 and above. However, the size of the register (186 risks as at March 2026) makes it unrealistic for Board members to scrutinise it in any meaningful way. The Corporate Risk Register is always scheduled at the end of the Board meeting and is provided for noting. The minutes

		of Board meetings only ever record that it was noted and there is never any record of a discussion of any of the risks contained within it.
6	Risk Management & Board Assurance Framework Internal Audit Apr 26	Sub-Committee Review of BAF - Whilst there is increased evidence of Board sub-committees reviewing issues that are recorded on the BAF, there remains an inconsistency of approach and a lack of an explicit link back to the strategic risks allocated to each Board committee.
7	1 Jul Escalation Board letter dated 14 Jul	The health board's risk register is unclear and some of the highest risks including quality, culture, access, productivity and performance, have remained unresolved for a prolonged period.
8	1 Jul Escalation Board letter dated 14 Jul	Concerns remain regarding organisational culture and the effectiveness of leadership and governance arrangements. In particular [2 of 5 bps]: • The need for a single and coherent view of organisational risk aligned to Board oversight and delivery arrangements. • The pace of delivery and delivery of mitigating actions against longstanding organisational risks
9	1 Jul Escalation Board letter dated 14 Jul	At the next meeting, the health board must demonstrate tangible evidence that planning activity has translated into measurable improvement and delivery, with more detail around the actions undertaken to improve the position across [1 of 4 bps]: • Risk identification and oversight…
10	Independent Assessment Aug 26	The current governance system is not serving the health board adequately in anticipating risks and issues and therefore providing an opportunity to develop mitigation plans.
11	Independent Assessment Aug 26	The health board has moved to a single digital risk management system AMaT (Audit Management and Audit Tracking) and published a new risk management policy in February 2026. This is a welcomed development and streamlines the previous disparate approach to recording risk. Whilst the leadership has identified the need to drastically improve risk management the IAs understand that there is not a current improvement plan in place. The IAs believe urgent and focussed attention is required here to strengthen this critical aspect of governance. A necessary next step is for CAVUHB to assure itself that its workforce understands and has the capability to effectively manage risk.
12	Independent Assessment Aug 26	Risk management is poorly understood by staff and underdeveloped across the health board.
13	Independent Assessment Aug 26	Urgently address the approach to risk management including the identification, classification, reporting of risk and importantly the required action needed to mitigate risk. In addition, the health board should discuss and agree its risk appetite, risk tolerance and how to prioritise and balance risk across the various domains.

The aim of this report is to:

1. Address the above points.
2. Introduce the revised Corporate Risk Register for discussion and approval.

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

Introduction

This section seeks to set out:

1. A brief description of our Risk Management Framework as it stands today.
2. What we have done in the last 2 years to get us here – the plan and delivery.
3. What the current maturity of the framework is.
4. What the next steps will be.
5. How this speaks to the observations and actions set out in the above section.
6. How this will be tested.

Risk Management Framework

There's 3 layers:

1. Board Assurance Framework (BAF).

While it features in the risk management framework, the BAF is not primarily a risk register per se. It is the framework that we use to link the 4 strategic objectives through the 6 strategic portfolios and align them to CVUHB Committees. It identifies 6 strategic risk themes that apply to every objective and group strategic level themes that individually or collectively could prevent delivery of the strategy. This is a slow moving, reference tool that should be used as contextual document to the primary focus, which should be the delivery of the strategy.

2. Corporate Risk Register (CRR).

This is the document that seeks to expose the most significant operational risks within the organisation to a Board, Committee and Leadership level.

3. Organisational Risk Register (ORR).

This is the floor to Board, information-rich register of all risks in the organisation that can be used by and interrogated by every person in the organisation. It changes daily and currently captures ~1,470 risks within the AMAT risk module that has been co-designed by CVUHB and AMAT and is now being made available to NHS organisations across England and Wales.

What has been done?

The below chronology covers some of the key actions and discussions that have taken place over the last 2 years. It is set out in part to respond to the point in the IA report that there has been no improvement plan for risk and seeks to assure the Committee that there has been both a process and progress.

Date	Source	What
Apr 24	Internal Audit	Despite reasonable assurance, DCG drew the conclusion that CVUHB required a single, organisation-wide risk register.
Jun 24	Board Development	Full review of the BAF to align with the then recently approved strategy refresh and align with Committees
Sep 24	Board	Approval of the changes resulting from the above

Sep 24	AMAT	First meeting with AMAT to commence the co-design of an NHS Risk Module within their software
Jul 25	SLT	SLT briefed on proposal to switch to a single system – endorsed.
Aug 25	Board CRR Report	T&F Group established to introduce and train organisation on developing AMAT module
Oct 25	T&F Group	All 20+ risks migrated to AMAT
Nov 25	Board CRR Report	CRR to Board presented from AMaT for first time
Feb 26	SLT	Update on new risk management policy and progress on digital migration and oversight of risk
Feb 26	Audit Committee	Updated Risk Management Policy approved to reflect the significant changes of having a single system
Mar 26	Board	CRR report update on progress with digital migration and risk oversight arrangements
Apr 26	T&F Group	All risks migrated to AMAT – 70+ risk registers are no longer used in the organisation
May 26	Audit Committee	1. Update on Risks transferred to AMAT and action to report to Audit Committee on new CRR in Nov 26. 2. Internal Audit report on risk management (reasonable)
May 26	Board	1. Standing CRR report confirms transition to AMAT completed and provides analysis on data held 2. Reports that the T&F group will transition to an organisational risk management group (ORMG)
Jun 26	Quality Committee	All quality tagged risks scoring 20+ in ORR reported
Jul 26	People and Culture Committee	All people and reputational risks scoring 20+ in ORR reported
Jul 26	Finance and Performance Committee	All finance and performance tagged risks scoring 20+ in ORR reported to Committee
Jul 26	Management Executive Meeting	CRR Discussion
Aug 26	SLT	ORMG TORs approved
Aug 26	Management Executive Meeting	CRR Discussion
Sep 26	Audit Committee	Endorsement of the CRR

In addition to the above it should be noted:

1. Digital and Infrastructure Risks are a regular feature of the D&I Committee.
2. The CRR has been reported to every Board meeting.
3. Risk features in Clinical Board Reviews and has evolved with the use of AMAT. The format is that the CB will speak to their key risks in each meeting so that there is timely exposure of them with the Execs and a focused discussion on the mitigations in place or intended. In response, the CG team will provide analysis of their wider risk management so they can use it to manage their processes within their CB.
4. Each CB has established its own internal system of risk management that has been used to validate the risks during the migration and then moderate the scoring, monitor actions etc.
5. The CG team have attended numerous risk training and moderation meetings with CBs/Dirs.

Where does this place us today?

There is documentation and correspondence relating to each of the lines in the table above which has focused on established meetings as a shorthand for the much wider work that has been undertaken across the organisation.

The Committee should be assured that this work amounts to the identification of the shortcomings of the Risk Management Framework as it was 3 years ago, and a resulting plan of work that has been identified and then delivered as stated, with the remaining steps set out below.

The transfer to the AMaT system has been overwhelmingly welcomed by CBs and Directorates and the burgeoning use of the system is encouraging and will continue to improve and be monitored through the ORMG and CB Reviews.

<u>Corporate Risk Register (CRR)</u>

A key finding of the Internal Audit report in Apr 26, which has manifested in slightly less specific ways in the engagement at Escalation Boards and the IA Report, is that the CRR was too large and that there was a resulting inconsistency in how the Board, Committees and Execs articulated the principle risks facing the organisation and the measures to respond to them.

The intent with the new AMaT system had been to use the scoring thresholds to derive the CRR; ie. the CRR would comprise of all risks scored at 20+. Initially this resulted in over 200 risks which has been reducing as moderation practices are harmonised through the ORMG and tested in the CB Reviews but is still too large. This work has resulted in 2 conclusions:

1. In an organisation of this size, there will never be a suitably manageable number of risks scoring 20+ that will allow a usable CRR to be discussed at Board and Committee level.

2. The risks are submitted and then managed within the CBs or Directorates. Therefore, to take the 20+ risks would mean to apply no filter that looks to establish whole organisation (corporate) themes and unifying risks.

As a result, a completely new CRR is presented today for **Board approval**.

The CRR is a result of the following process:

- AI analysis of the whole ORR on a variety of themes/prompts that each asked for a top 12 based on criteria such as by causative themes, effect/impact themes, holistic view assessing language rather than scoring and several other filters;
- this produced 6 different top 12 proposals (so 72 individual or overlapping risks) that were then shaped into a shortlist of 20 by DCG;
- this shortlist was workshopped by Execs in July into 13 corporate risks that articulated the risk, cause and impact for each one;
- these 13 CRs were then processed back through the ORR using AI to derive the mitigating actions being taken;
- this resulting product was workshopped once again by Execs in August to refine risk ownership and then review the listed mitigations.

The result is the CRR at Appendix 2.

The CRR will continue to evolve as the reviews continue and it should be dynamic enough to change between presentations. Additionally, it will feed into the strategic portfolio and plan delivery work where the appropriate steps will be articulated that speak in part to the mitigation of the risks.

What still needs doing?

Board and Committees

It is intended that the CRR will be taken to every other Public Board – 3 times a year. Each cycle will go through a similar process of using AI to analyse the data rich ORR to test the risks within the CRR, and this will the be tested against the risks being highlighted by CBs and Directorates in their reviews and discussed in SLT and Execs prior to submission to Board.

The relevant risks within the CRR will also report to the Committees as a framing document that can act to introduce the greater detail of the organisational risks contained within the ORR.

The BAF will continue to feature in all Committees as a reference document for items that speak to the delivery of the strategy. The changes made to the Quality Committee and the introduction of AAA reporting will be rolled out to other Committees which will then frame agendas within the context of the strategy delivery.

Organisation Management

CB and Directorate Reviews will continue to 'pull' a discussion on the key risks and 'push' data that will ensure continuing cleansing of risk data and focus and learning of the workforce. The ORMG will augment this through the establishment of training, bespoke assistance and best practice.

Alignment

The ORR is already used to inform planning and decision making (the Capital Prioritisation work is a good example of this within Estates) and this will continue through the 27/28 planning process and the wider integrated improvement plan so that the risk discussions are linked through to these delivery and monitoring vehicles (with the evolving performance management framework and quality management system key too).

Risk must never become a task and finish in of itself and must inform these established or establishing golden threads.

Policy

The Risk Management Policy will update as required.

How does this align with the actions set out in the first section from the 4 areas?

	Source	**Observation/Action/Recommendation**
1	Structured Assessment	CRR at Board and Committees
Response - CRR to Board Sep 26 for substantive discussion and then to Committees as directed.		
2	Internal Audit Apr 26	Risk Management Documentation

Response – completed		
3	Internal Audit Apr 26	Data Cleansing
Response – ongoing since Oct 25 and will continue to feature at ORMG and CB Reviews		
4	Internal Audit Apr 26	Clinical Board Executive Reviews
Response – push and pull approach as set out above derived from the ORR and ORMG to continue to deliver training and best practice		
5	Internal Audit Apr 26	Corporate Risk Register size
Response – new CRR at Board today		
6	Internal Audit Apr 26	Committee Review of BAF
Response – BAF appears in all Committees and will evolve with the changes to be rolled out re AAA reporting etc following Quality Committee example		
7	Escalation Board letter	Risk register is unclear and some have remained unresolved.
Response – ORR is a data-rich source of information that is managed in CBs/Dirs and through ORMG and CB Reviews. The new CRR is clear and purposeful. Some will remain unresolved.		
8	Escalation Board letter	Need a single/coherent view aligned to oversight and delivery with pace to mitigations.
Response – ORR is single point of truth and CRR is credible, corporate overview for use at leadership level. Alignment with delivery and management of mitigations will continue to evolve.		
9	Escalation Board letter	Must demonstrate planning has translated to measurable improvement and delivery of risk identification and oversight.
Response – this report serves as such evidence.		
10	Independent Assessment Aug 26	The current risk governance system is insufficient
Response – co-designed ORR is now being offered to other NHS organisations and the AI analysis is enabled by it. The CRR will evolve through challenge to provide leadership an effective tool.		
11	Independent Assessment Aug 26	There is not a current improvement plan for risk and no assurance that the workforce has the capability to effectively manage risk.
12	Independent Assessment Aug 26	Risk management is poorly understood by staff and underdeveloped across the health board.
Response – this report seeks to set out work undertaken and reported to Board, Committees and Leadership and the work of the CB Reviews and ORMG to grow capability with the new software		
13	Independent Assessment Aug 26	Urgently address the approach to risk management.
Response – the system and framework is established and work will continue iteratively on risk appetite and tolerance.		

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

1. Corporate Risk Register

Recommendations:

a) **Note** the work undertaken to date to develop and deliver and plan to improve risk management in CVUHB.
b) **Note** how the content of the report speaks to the actions and observations set out in the background section.

c) **Approve** the CRR as an appropriate but dynamic representation of the organisation's key, corporate risks.

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		2. Providing Outstanding Quality	
3. Delivering in the Right Places		4. Acting for the Future	

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

Prevention	X	Long Term	X	Integration	X	Collaboration		Involvement	X

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

Yes		No	X	Corporate oversight not a specific service proposal

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

Risk: No
It's about risk, but it doesn't introduce risk
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: Yes
How we manage risks considers and can expose us to reputational considerations
Socio Economic: Yes/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:

Risk title	Risk title	Risk owner	Risk event	Risk cause	Risk effect	Key controls	Assurance on controls	Gaps in controls	Treatment plan	Barriers
1	Length of Stay	EDs Nursing and Medicine	Patients remain in hospital longer than clinically necessary.	Patient-flow and discharge processes are not consistently optimised; related risks identify limited MDT collaboration, therapy capacity, senior decision-maker availability, medicines support and onward-care capacity.	Avoidable harm including deconditioning, poorer experience, delayed admission for other patients, capacity constraint and additional cost.	Daily bed-management and flow meetings; discharge planning from admission; specialty trajectories; outlier MDT huddles; DTOC review; therapy prioritisation; escalation routes; medicines-support pathways.	Proposed assurance: weekly length-of-stay and stranded-patient trends; discharge-delay reason analysis; outlier volumes; readmissions; harm reviews; actions and escalation evidenced through governance minutes.	Variable MDT participation; therapy and senior decision-maker capacity; medicines-support variation; delayed onward-care placements; inconsistent real-time data.	Standardise discharge pathways and escalation triggers; establish skilled outlier MDT support; validate delay reasons; address therapy and medicines bottlenecks; track recurring constraints to closure.	Therapy and clinical workforce funding; social-care and housing availability; community pharmacy capacity; cross-organisational dependencies.
2	UHW Estate	DoF	Estate or critical infrastructure failure, or increased infection prevention and control incidents, disrupts care at UHW.	Age, condition and configuration of the UHW estate, with maintenance and replacement needs exceeding available capacity or funding.	Delayed or unsafe care, patient harm, service interruption, reduced staff morale and productivity.	Risk-based planned and reactive maintenance; statutory inspections; fire, water, ventilation and asbestos controls; IPC audits; incident reporting; temporary mitigations; business-continuity and decant arrangements.	Proposed assurance: current condition surveys; critical backlog profile; statutory compliance and IPC audit results; repeat-fault trends; incident and service-disruption data; action closure reported to the relevant committee.	Ageing fabric and plant; repeated environmental failures; capital backlog; constrained decant space; reactive rather than permanent fixes; single points of failure.	Prioritise critical backlog using safety and continuity criteria; agree permanent remedies for repeat failures; protect critical plant; test decant and continuity plans; monitor delivery and residual risk.	Capital affordability, increased contract cost for survey work wout of line with budget resulting in less remedial works being undertaken: limited decant capacity; disruption during works; specialist contractor availability; interdependencies across ageing
3	In-year Financial Position	DoF	The organisation fails to maintain control of the in-year financial position and incurs an unaffordable overspend.	Financial planning, forecasting, accountability or delivery grip is insufficient to identify and correct adverse variance promptly.	Funding is diverted from wider public services and the organisation cannot invest or transform as planned.	Monthly financial reporting and forecasting; Standing Financial Instructions; budget-holder accountability; monthly Financial Clearance; weekly Cost Improvement Programme tracker; Executive Performance Reviews; Finance & Performance Committee and Board oversight.	Monthly Monitoring Returns and Welsh Government review; internal audit evidence; forecast accuracy; savings delivery and recurrent/non-recurrent split; cash and payment performance; Targeted Intervention de-escalation evidence.	Gap between planned and recurrent savings; operational cost pressures; forecast uncertainty; limited discretionary spend; delayed delivery of transformation benefits.	Refresh the recovery forecast; assign named corrective actions; validate recurrent savings and benefits; strengthen weekly CIP challenge; escalate adverse run-rate and cash risks promptly. Internal turnaround moving to formal turnaround with the support of PWC in driving the delivery of identified actions.	Prioritisation, decision making pace, trade off's and resource allocation
4	Clinical Engagement	EDs Nursing, AHPs and Medicine	Strategic and operational decisions are made without sufficient clinical leadership or engagement.	Healthcare professionals are not consistently enabled, activated or aligned to population needs and transformation priorities.	Decisions may not be clinically informed or in the population's best interests, and workforce support for transformation may be lost.	Clinical boards and professional forums; multidisciplinary governance; clinical input to pathway and transformation design; quality-impact assessment; defined escalation and consultation routes.	Proposed assurance: attendance and representation by profession/service; decision logs showing how clinical advice influenced outcomes; action closure; staff survey and engagement feedback; quality and transformation benefit measures.	Uneven participation; limited protected leadership time; unclear decision rights; inconsistent feedback to clinicians; operational pressure and change fatigue.	Define a Trustwide clinical-engagement standard; protect leadership time; require clinical sign-off for material changes; track representation, influence and closed feedback loops.	Operational pressure; change fatigue; workforce availability; competing professional priorities.
5	Lost to Follow-up	COO	A patient is not followed up after a diagnostic result, referral, review or other clinically significant event.	Follow-up pathways are fragmented and reliant on manual hand-offs, lists and document movement; ownership, timeframes and escalation are not consistently defined or auditable.	Crucial information is missed, causing delayed diagnosis or treatment and avoidable patient harm.	Monthly extracted follow-up lists; patient flags until outcomes are completed; SOPs and defined timeframes; RTT validation; results acknowledgement; overdue-case exception reports; clinical escalation and harm review.	Proposed assurance: monthly overdue volumes and ageing; completion rate within standard; audit of acknowledgement and outcome coding; incident and harm-review trends; evidence that exceptions and actions are closed.	Manual processes; multiple systems; large follow-up cohorts; inconsistent outcome recording; weak end-to-end ownership; incomplete performance data.	Implement closed-loop tracking with accountable owner and deadline at each hand-off; reconcile backlog; automate alerts and escalation; audit high-risk pathways and report confirmed harm.	System interoperability; data quality; workforce capacity; legacy backlogs; cross-provider dependencies.
6	Diagnostic Delays	COO	Diagnostic investigation or reporting is delayed, delaying clinical decision-making and treatment.	Demand exceeds sustainable capacity and pathways are constrained by specialist workforce, equipment availability, reporting backlogs, referral quality and variable flow across modalities.	Disease may progress, outcomes and experience worsen, and patients may suffer avoidable harm.	Clinical prioritisation and urgent-suspected-cancer flags; waiting-list validation; extended working; outsourcing/insourcing; pathway-flow changes; urgent-case MDT escalation; turnaround and backlog reporting; harm reviews.	Proposed assurance: modality-level demand, capacity, backlog and longest-wait trends; reporting turnaround; urgent-case compliance; outsourcing performance; incidents, concerns and completed harm reviews.	Specialist workforce shortages; reporting bottlenecks; equipment downtime; rising demand; incomplete demand-and-capacity modelling; variable referral and pathway productivity.	Complete modality-level demand-and-capacity analysis; recover longest waits; protect urgent pathways; optimise reporting flow; address equipment resilience; strengthen prospective harm surveillance.	Specialist workforce shortages; equipment and estate constraints; funding; sustained demand growth.
7	Digital Immaturity	Dir Digital	Digital systems fail to support integrated, reliable and efficient care processes.	Systems are aged, unintegrated or absent, with inconsistent data standards and continued reliance on manual processes.	Data may be incorrect or isolated, services become less effective and efficient, and delivery costs and time increase.	Digital architecture and prioritisation governance; legacy-system and dependency register; SOPs and data ownership; secure communication; change control; staff training and competency; clinical validation; data-quality and benefits monitoring.	Proposed assurance: maturity and architecture assessment; end-of-life technology profile; outage and incident trends; data-quality audits; training and competency records; adoption, benefits and action-closure reports.	End-of-life systems; manual and paper-based work; unsupported technology; incomplete integration; unclear data accountability; constrained digital skills and investment.	Agree target architecture; prioritise high-risk legacy replacement and integrations; establish data owners and standards; digitise high-risk manual workflows; track adoption, benefits and residual dependencies.	Capital and revenue affordability; supplier capacity; workforce readiness; implementation disruption.
8	Cyber Security	Dir Digital	A cyber incident compromises the confidentiality, integrity or availability of information, systems or digital services.	Cyber threats are increasing in volume, sophistication and persistence, while technical or human vulnerabilities remain.	Patient safety, operational performance, privacy and regulatory compliance are adversely affected.	Security monitoring; asset inventory; access controls and MFA; vulnerability and patch management; segregated and tested backups; supplier assurance; staff awareness; incident response integrated with business continuity and disaster recovery.	Proposed assurance: penetration and vulnerability tests; critical-patch and MFA coverage; phishing results; backup restoration tests; cyber exercise outcomes; response and recovery times; supplier remediation and governance action closure.	Legacy and end-of-life technology; untested plans; incomplete asset visibility; third-party exposure; patching constraints; limited specialist on-call and response capacity.	Remediate critical vulnerabilities; complete asset inventory and MFA rollout; exercise cyber response and recovery; integrate plans with organisational continuity; strengthen supplier controls and on-call resilience.	Legacy-system dependencies; specialist skills; funding; supplier responsiveness; operational downtime constraints.
9	Fragile Services	ED Medicine	A small or specialist service cannot sustain safe capacity and capability as demand grows.	The service relies on scarce specialist skills, limited workforce resilience and vulnerable processes or infrastructure.	Patient choice or access is restricted, continuity deteriorates and patients may experience avoidable harm.	Consistent fragility assessment; workforce and succession plans; vacancy and demand monitoring; cross-cover and network arrangements; escalation triggers; service-continuity plans; prioritisation of high-risk pathways.	Proposed assurance: vacancy and turnover trends; single-person dependencies; waiting times and activity loss; cancelled or restricted services; continuity tests; network capacity; delivery of recruitment and succession actions.	Single-handed services; specialist vacancies; sickness and leave vulnerability; long recruitment and training lead times; insufficient cross-cover; rising demand and limited alternatives.	Apply the fragility framework to all priority services; identify single points of failure; agree networked and cross-cover models; develop succession pipelines; test continuity and escalation arrangements.	Vacancy controls and financial constraints; national workforce shortages; training lead times; geography; partner capacity; staff burnout and retention.

10	Accreditation Compliance	ED AHPs	A service loses, fails to obtain or cannot maintain required accreditation.	Changing accreditation standards exceed available capacity, capability or the suitability of the physical environment.	Services operate without accreditation or cease, causing poor outcomes, restricted access and reputational damage.	Accreditation inventory and accountable leads; QMS aligned to each standard; SOP, audit, competency and document control; non-conformance and change-control tracking; multidisciplinary governance; capital and environmental action plans.Close monitoring of environmental monitoring results for PSU	Proposed assurance: accreditor correspondence and external assessments; previous accreditation/licensing; internal audit and Q-Pulse reports; non-conformance ageing and closure; competency records; outcome benchmarking; committee oversight.	Known infrastructure and environmental non-compliance; incomplete accreditation inventory; limited quality-resource capacity; overdue audit or change-control actions; investment dependency.	Confirm every accreditation and deadline; risk-rank non-conformances; protect QMS capacity; close overdue actions; deliver required estate schemes; maintain commissioner and accreditor engagement.	Capital and revenue investment; estate limitations; specialist quality workforce; competing transformation programmes; external accreditor and commissioner timescales.
11	Commissioning Architecture	DoF	Commissioning arrangements fail to define and secure services that meet population needs.	Internal and external commissioning architecture is inconsistent and under-developed, with unclear standards, requirements and accountability.	Access to appropriate care is limited, resources are poorly aligned and patients may experience harm.	Commissioning operating model; population-needs assessment; contracts and service specifications; agreed standards and outcomes; finance/clinical/commissioner review; performance escalation; individual funding route only as a controlled exception.	Proposed assurance: specification coverage; access and equity by geography; out-of-area activity; outcome and waiting-time metrics; contract performance; funding alignment; actions and escalations through partnership governance.	Unclear roles, accountability and governance arrangements; services without formal commissioning arrangements; inconsistent, out dated or absent specifications; fragmented outcome and performance data; no robust performance management framework in place; reliance on case-by-case approval; cross-organisational dependencies.	Map all non-commissioned or inconsistently commissioned pathways and services; develop population health intelligence to inform future commissioning; agree responsibilities and standards; embed commissioning governance arrangements for externally and internally commissioned services with clear reporting and escalation	Commissioner and partner agreement; financial constraints; statutory boundaries; data and intelligence availability; commissioning and contracting capability and capacity; alternative-provider capacity.
12	NICE Guidance and Drug Costs	ED Medicine	Implementation of NICE-recommended therapeutics creates unaffordable growth in drug expenditure and displaces other care.	NICE technology appraisals and AWMSG requirements, Drug Tariff and concessionary-price volatility, shortages, prescribing-volume growth and service transfers increase expenditure faster than funding and delivery capacity.	Drug expenditure exceeds allocation; savings options narrow; access may become inequitable; mandated therapies displace other treatment or service investment; unsupported implementation may create long waits and clinical risk.	Medicines horizon scanning; formulary and Medicines Management governance; monthly finance review; tariff and shortage monitoring; value-based prescribing and waste reduction; procurement; uptake and pathway-capacity planning.	Proposed assurance: national medicines analytics; budget variance and forecast accuracy; uptake against NICE/AWMSG assumptions; audit against clinical guidance; procurement and switch savings; outcomes and governance action closure.	Tariff and concessionary-price volatility; mandatory access requirements; uncertain uptake; limited non-detrimental savings; insufficient pathway capacity; late funding decisions.	Maintain a rolling medicines and NICE pipeline forecast; align finance, pharmacy and clinical capacity plans; optimise procurement and formulary use; audit outcomes, equity, uptake and variance monthly.	National guidance timing; market pricing and shortages; patient demand; funding allocations; limited alternatives; workforce and service capacity needed for safe implementation.
13	Culture	CEO and ED People and Culture	The organisation's culture is not optimised to support consistently high-quality service delivery and staff experience.	Practices and standards are applied inconsistently across a large and diverse workforce, while variable leadership behaviours, morale, motivation, engagement and psychological safety limit ownership and continuous improvement.	Standards of care, patient experience and staff experience may vary or deteriorate, resulting in avoidable harm, poorer outcomes, reduced productivity and loss of public confidence.	Values and behaviours framework; Board and executive leadership expectations; workforce policies and professional standards; recruitment, induction, appraisal and leadership development; staff survey and pulse checks, culture early warning system; Freedom to Speak Up and grievance routes; wellbeing and occupational-health support; incident, complaint and quality-governance review; equality and inclusion arrangements.	Proposed assurance: staff survey and pulse results by service and Strategic equality plan outcomes inc WES -protected characteristic; engagement and psychological-safety measures; appraisal and mandatory-training compliance; turnover, sickness, vacancies and retention; speaking-up, grievance and disciplinary themes; patient complaints, incidents and quality outcomes; triangulated hotspots, action closure and sustained improvement reported through People and Quality governance.	Inconsistent application of policies - people practices and standards; variable leadership behaviours and accountability; uneven staff engagement and psychological safety; low engagement score / morale or change fatigue in pressured services; limited triangulation of workforce and quality data; actions may not be evaluated for impact.	Define and embed a Trustwide culture and behaviours standard linked to high-quality care; set measurable expectations for leaders and teams; identify hotspots through triangulated workforce, safety and patient-experience data; require local improvement plans with named owners and deadlines; strengthen speaking-up feedback; evaluate whether actions improve culture and care outcomes.	Operational and financial pressure; workforce shortages and turnover; leadership capability / capacity; change fatigue; variation between services and professions; fear of speaking up; time required for behavioural change; difficulty attributing quality outcomes directly to culture.

Report Title:	Pharmaceutical Needs Assessment				Agenda Item No:	8.1
Meeting:	Board	Public	X		Meeting Date:	24.09.26
		Private				
Status	Assurance		Approval	X	Information/Noting	X
Lead Executive Title:	Executive Director of Public Health					
Report Author Title:	Director of Ops – Primary Care, PCIC					

Main Report

Background and Current Situation:

The Health Board published its first Pharmaceutical Needs Assessment (PNA) on 1 October 2021 (see Pharmaceutical Needs Assessment 2021 - Cardiff and Vale University Health Board). To meet legal obligations - the National Health Services (Wales) Act 2006, the Public Health (Wales) Act 2017 and the NHS (Pharmaceutical Services) (Wales) Regulations 2020 – PNAs must be revised every five years, so the Health Board is required to publish its next by 1 October 2026.

Papers have been prepared for and approved by SLT on the purpose, content and development approach for the PNA. It was agreed the final PNA document would be provided to SLT for formal sign off in early September to enable the PNA to be noted at the Board on 24 September 2026, prior to publication. This paper provides a brief summary of the process undertaken and the outcome of the consultation.

The process for developing the PNA commenced in January 2026. A Steering Group was established and chaired by the Director of Ops Primary Care, PCIC Clinical Board to provide oversight of the work undertaken by the Primary Care Commissioning Community Interest Company (PCC CIC). Consultation was undertaken from 8 July to 6 September, in line with the regulatory requirement for a minimum of 60 days.

There were 187 responses to the consultation, of which there were 175 personal responses. The majority of individual responses were from people living in the Pentyrch area who have raised concerns over a long period of time relating to the potential move of the pharmacy from Pentyrch to the new GP premises at Rhydlafar. A response was also provided by Community Pharmacy Wales which was supportive of the assessment and conclusions drawn.

As can be seen within the report, the majority of respondents felt the purpose of the PNA had been explained and there was agreement to the conclusion in the PNA that pharmaceutical services were able to meet current need, as well as the future needs over the next 5-year period.

The Steering Group considered the detailed information included in the PNA and discussed the demographic changes and health needs, planned housing developments and the location of and travel times to pharmacies across Cardiff and the Vale.

There was some discussion on the approach taken in some other Health Boards to 'future-proofing' the PNA to reflect planned housing developments, closure of pharmacies or reduction in Saturday hours. It was however felt better not to speculate on future changes and to base decisions on the information available at the time.

The Steering Group agreed the final PNA which was included for approval and sign off by SLT on 17 September. Based on the information available in the PNA, the conclusion is that pharmaceutical services are able to meet current need and also expected to meet future needs over the next 5-year period.

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

Developing and publishing a revised PNA by 1 October 2026 is a key Health Board responsibility. The PNA includes detailed information on current service provision relative to population need for pharmaceutical services and considers whether there are any gaps in provision in relation to future need over the next 5-year period.

The PNA development process has been undertaken to align with the requirements set out in relevant legislation and non-statutory guidance. A Steering Group was established to ensure oversight and delivery, including work commissioned from PCC CIC.

A critical component of this process is effective stakeholder engagement and consultation. The consultation period ran from 8 July to 6 September. There was support for the outcome of the PNA which has determined there is no gap in provision of pharmacy services to meet both current and future need.

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

Appendix 1 – Final PNA.

Due to the large size, this document is available to view in the supporting documents folder on the Cardiff and Vale UHB website: 2026 - 2027 Public Board Meetings - Cardiff and Vale University Health Board
For colleagues, it is available to view on the Board MS Teams Channel.

Recommendations:

a) Board to note the PNA, which has been approved by SLT for publication on or before 1 October 2026.

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	x

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

Prevention		Long Term	x	Integration		Collaboration		Involvement	

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

Yes	x	No		

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

Risk: No (delete as appropriate)

This paper focuses purely on the requirements and approach for producing a Pharmaceutical Needs Assessment.

Safety: /No

This paper focuses purely on the requirements and approach for producing a Pharmaceutical Needs Assessment.

Financial: Yes
The paper focused on the requirements and approach of producing and publishing a PNA. There is a cost associated with the work undertaken by the PCC CIC and some translations costs.
Workforce: No
Not applicable
Legal: Yes
There are legal frameworks in relation to the statutory duty to produce and publish a PNA and sets out the requirements in relation to content and approach.
Reputational: Yes
There are reputational risks if the PNA is not produced in line with the requirements set out. However, the process undertaken has ensured compliance with the requirements set out in regulations and guidance.
Socio Economic: Yes
The regulations set out specific groups and needs that must be considered in the development of the PNA.
Equality & Health: No
Although the regulations set out specific groups and needs that must be considered in the development of the PNA.
Decarbonisation: Yes
The PNA takes into consideration the needs of people when considering the location of pharmaceutical services.
Welsh Language: Yes
Consideration has been given and the final report will be published in both Welsh and English.

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:
Strategic Leadership Team	17.09.2026