# Public Quality Committee
## 28th July 2026
## 09:00 via MS Teams
## Public Agenda

| 1.<br>09:00 | Standing Items | Assurance<br>Approval<br>Noting/Info | Lead |
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| 1.1 | Welcome, Introductions & Apologies | | Ceri Phillips |
| 1.2 | Declarations of Interest | | Ceri Phillips |
| 1.3 | Minutes of the Quality Committee Meeting held on 02.06.2026 | | Ceri Phillips |
| 1.4 | Action Log | | Ceri Phillips |
| 1.5 | Chair's Actions taken since last meeting - *none* | | Ceri Phillips |
| **2.<br>09:05** | **Quality Performance Reporting** | | |
| | *No items.* | | |
| **3.<br>09:05** | **Items for Oversight / Scrutiny** | | |
| 3.1<br>*30 mins* | Clinical Board Highlight Reports:<br>• *3.1.1 - Medicine CB*<br>• *3.1.2 - Surgery CB*<br>• *3.1.3 - Children & Women CB*<br>• *3.1.4 - PCIC CB*<br>• *3.1.5 - CD&T CB*<br>• *3.1.6 - Specialist Services CB*<br>• *3.1.7 - Mental Health CB*<br><br>*Clinical Board QSE Minutes can be found **here**.* | Assurance | Execs |
| 3.2<br>*10 mins* | Clinical Safety Group Highlight Report - *CSG minutes can be found **here**.* | Assurance | Alex Scott |
| 3.3<br>*10 mins* | Clinical Effectiveness Committee Highlight Report | Assurance | Alex Scott |
| 3.4<br>*0 mins* | Annual Reports:<br>• *3.4.1 - Annual Quality Report* | Noting | Alex Scott |
| 3.5<br>*10 mins* | Regulation 28 Prevention of Future Deaths Report – Health Board Response and Assurance Arrangements | | Angela Hughes |
| **4.<br>10:05** | **Strategy: Providing Outstanding Quality** | | |
| 4.1<br>*5 mins* | Board Assurance Framework (May 2026) | Assurance | Matt Phillips |
| **5.<br>10:10** | **Shaping our Population Health and Place-Based Partnerships:** | | |
| 5.1<br>*15 mins* | *Public Health Work 6 Month Update (including Targeted Intervention Indicators)* | Assurance | Claire Beynon / Tom Porter |
| 5.2<br>*10 mins* | *No-smoking and Smoke-Free Environment Policy Compliance at Cardiff & Vale Hospital Site (Appendix 1* | Assurance | Claire Beynon / Huw Brunt |

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| | *– Smoking Enforcement Bi-annual Review can be found **here**)* | | |
| **6.**<br>**10:35** | **Shaping our Quality, Value & Sustainability** | | |
| 6.1<br>*0 mins* | *No items.* | | |
| **7.**<br>**10:35** | **Shaping our Future Clinical Services** | | |
| 7.1<br>*10 mins* | *Cardiology Review Update* | Assurance | Paul Bostock |
| 7.2<br>*10 mins* | *JACIE Inspection Update* | Assurance | Jess Castle |
| **8.**<br>**11:10** | **Policies for Approval** | | |
| 8.1<br>*5 mins* | UHB 597 - Accessible Standards and Communication Policy *(EHIA can be found **here**)* | Approval | Angela Hughes |
| **9.**<br>**11:10** | **Items for Noting / Information** | | |
| | *No items.* | | |
| **10.**<br>**11:10** | **Are there any items from the meeting that require escalation to Board?** | | |
| **11.**<br>**11:10** | ***Private Meeting Business:***<br>***1. Minutes from previous meeting***<br>***2. Any Urgent / Emerging Themes*** | | |
| **12.** | **Any Other Business** | | |
| **13.** | **Review of the Meeting** | | |
| **14.** | **Date & Time of Next Meeting:**<br>*29th September 2026 via MS Teams – no meeting in August due to summer holidays* | | |

**Draft Minutes of the Public Quality Committee**
**Held on 30th June 2026 via MS Teams**

To view the meeting: Cardiff & Vale University Health Board - Public Quality Committee Meeting 30.06.2026 - YouTube

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| **Chair:** | | |
| Ceri Phillips | CP | Committee Chair / UHB Vice Chair |
| **Present:** | | |
| Judi Rhys | JRH | Independent Member – Third Sector |
| Rachna Upadhya | RU | Independent Member - General |
| **In Attendance** | | |
| Claire Beynon | CB | Executive Director of Public Health |
| Vicki Burrell | VB | Senior Service Improvement Programme Manager |
| Jessica Castle | JC | Director of Operations – Specialist - Joined for agenda item 7.1 |
| Emma Cooke | EC | Executive Director of AHPs, Health Scientists and Community Services Development |
| David Fluck | DF | Executive Medical Director |
| Natasha Goswell | NG | Deputy Executive Nurse Director |
| Angela Hughes | AH | Assistant Director of Patient Experience |
| Aled Roberts | AR | Associate Medical Director Patient Safety and Clinical Effectiveness |
| Jason Roberts | JR | Executive Nurse Director |
| Alexandra Scott | AS | Assistant Director of Quality and Patient Safety |
| Catherine Wood | CW | Deputy Chief Operating Officer |
| Frankie Ogden | FO | Head of Corporate Governance |
| **Additional Attendees** | | |
| Omar Aldalati | OA | Consultant Cardiologist |
| David Hanna | DH | Clinical Board Director - Specialist |
| Helen Luton | HL | Interim Director of Nursing CD&T |
| Scott Gable | SG | Cellular Pathology Service Manager |
| Catherine Twamley | CT | Interim Director of Nursing for Specialist Services Clinical Board |
| Peter O'Callaghan | PO | Consultant Cardiologist and Heart Rhythm Specialist |
| Lauranne Cullen | LC | Regional Director for Llais |
| **Secretariat** | | |
| Nathan Saunders | NS | Senior Corporate Governance Officer |
| **Apologies** | | |
| Kirsty Williams | KW | UHB Chair |
| Paul Bostock | PB | Chief Operating Officer |
| Matt Phillips | MP | Director of Corporate Governance |
| Suzanne Rankin | SR | Chief Executive Officer |
| Stephen Riley | SR | Independent Member – University |

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| **QC2 26/06/30/1.1** | **Welcomes, Introductions & Apologies**<br><br>Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh and apologies for absence were noted. | |
| **QC2 26/06/30/1.2** | **Declarations of Interest**<br><br>No declarations of interest were raised. | |

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| **QC2 26/06/30/1.3** | **Minutes of the Committee meeting held on 02.06.2026**<br><br>The minutes of the Committee meeting held on 02.06.2026 were received.<br><br>**The Committee resolved that:**<br>a) The minutes of the meeting held on 02.06.2026 were approved as a true and accurate record of the meeting. | |
| **QC2 26/06/30/1.4** | **Action Log following the Meeting held on 02.06.2026**<br><br>The Action Log following the Meeting held on 02.06.2026 was received and discussed.<br><br>**The Committee resolved that:**<br>a) The Action Log from the meeting held on 02.06.2026 was noted. | |
| **QC2 26/06/30/1.5** | **Committee Chair's Actions**<br><br>No Chair's Actions were raised. | |
| | **Quality Performance Reporting** | |
| **QC2 26/06/30/2.1** | **Quality Performance Report**<br><br>Alexandra Scott (AS), Assistant Director of Quality and Patient Safety provided the following update on the development of the Integrated Performance Report (IPR):<br>• Work had continued since the previous Committee meeting, with indicators now being populated and Statistical Process Control (SPC) charts being developed.<br>• The report had been presented to a recent Board Development session, where feedback had been received regarding the accompanying narrative content.<br>• Feedback had been incorporated into the development process and that that all leads involved in developing the IPR were undertaking narrative training developed by Making Data Count.<br>• The first iteration of the report would be available for consideration at the next Committee meeting in July 2026. At that point, work would also commence on Phase 2 of the development programme, which would focus on the secondary quality indicators discussed by the Committee at its previous meeting, providing greater depth to quality oversight arrangements.<br><br>CP noted that he had recently attended a meeting at which the Chief Nursing Officer had provided insight into the national thinking around quality performance measures. He advised that he would discuss this information further with AS outside the meeting.<br><br>Judi Rhys (JRH), Independent Member Third Sector, welcomed the progress made and acknowledged the significant work undertaken within challenging timescales. It was noted that an iterative approach to development was appropriate.<br><br>AS agreed that an iterative approach had been beneficial, as it enabled performance data to be shared with the Committee without delaying implementation while further refinements and improvements were being made.<br><br>**The Committee resolved that:**<br>A) The Quality Performance Report was noted for assurance. | |
| | **Items for Oversight / Scrutiny** | |
| **QC2 26/06/30/3.1** | **Clinical Board Highlight Reports:** | |

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| | Jason Roberts (JR), Executive Nurse Director, introduced the Clinical Board Highlight Reports, noting that this was the first occasion on which the new reporting format had been presented to the Committee.<br><br>JR advised that, whilst each Clinical Board had submitted an individual report, there were several common themes emerging across the organisation, and highlighted the below:<br>• Workforce challenges were reported across a number of Clinical Boards, with vacancies and sickness impacting service delivery, particularly within PCIC, Mental Health, and Community Nursing services. Concerns were noted regarding delays in community care and the impact on patient flow, including prolonged hospital stays for some children awaiting community care packages.<br>• An improving position was reported in relation to incident management, with reductions in overdue high-level Datix incidents and Nationally Reportable Incidents (NRIs), supported through monthly executive oversight and improvement plans.<br>• Patient flow, access and waiting times remained significant concerns across Clinical Boards. Particular concern was noted regarding sustained levels of out-of-area placements within Mental Health services and continued focus on reducing length of stay and associated deconditioning risks.<br>• IP&C remained a key area of focus, with increases in C.difficile and E. coli infections highlighted. Positive progress was reported in some areas, including systematic improvement work within Medicine, although further improvements were required in other services, particularly in relation to MRSA and line-associated infections.<br><br>David Fluck (DF), Executive Medical Director, informed the Committee that the UHB was focused on articulating its three principal risks to Welsh Government (WG), which included length of stay, patient safety incident management, and lost to follow-up. DF suggested future highlight reports should place greater emphasis on these key quality risks and the areas requiring the most significant improvement.<br><br>CP welcomed the new reporting format and considered it a significant improvement.<br><br>JR emphasised that the strengthened reporting arrangements and risk management processes provided a clearer line of sight from Clinical Boards through to Board-level assurance.<br><br>CP observed that the reports provided an opportunity to inform other UHB Committees of factors affecting quality, including workforce challenges and estate-related concerns.<br><br>CP highlighted the importance of strengthening this proactive approach to help the UHB recognise and address concerns early, reducing the risk of significant quality failures.<br><br>JRH expressed concern regarding the increase in hospital-acquired infections and the reported link to the condition of the UHB‘s estate. JRH asked for evidence supporting this relationship and the actions available to address this.<br><br>JR acknowledged the significant challenges posed by the ageing estate and its potential impact on infection prevention and control. Whilst it was difficult to directly attribute infection rates to estate conditions due to the many contributing factors involved, the estate remained an important component of the overall IP&C strategy. Ongoing work included peer reviews of clinical environments, investment in maintenance and cleaning standards, and continued collaboration with Estates to ensure clinical areas remain safe and appropriate for patient care.<br><br>JRH raised concern regarding the risk associated with the liquidation of Richmond Services and the transfer of domiciliary care provision to a new provider and asked for more information. | |

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| | JR advised that the risks associated with Richmond Services entering liquidation had been carefully assessed and managed. Two complex care packages were affected: one concluded naturally, while continuity of care for the other was maintained through the same staff remaining in place under a newly rebranded provider. JR noted that the original concerns related to governance processes rather than direct patient care, and that appropriate risk mitigation measures were implemented while longer-term arrangements were developed.<br><br>Rachna Upadhya (RU), the Independent Member – General, asked how the UHB assured itself that learning arising from NRIs had been embedded into practice.<br><br>RU also asked for assurance that improvements in Datix and patient safety incident management reflected genuine quality improvement rather than merely the reduction of administrative backlogs.<br><br>AS explained that learning from NRIs was embedded through thematic analysis, which informed improvement programmes under the Quality Excellence Programme. Key areas of focus included deteriorating patients, lost to follow-up, IP&C, falls and pressure damage. These were supported by targeted improvement programmes, clinical audits, and ongoing oversight to ensure learning was implemented across the organisation.<br><br>In relation to Datix incidents, AS acknowledged that assurance was required to demonstrate that improvements reflected meaningful changes in practice and patient safety outcomes, rather than solely reducing backlogs. This would remain a continued area of focus.<br><br>CP asked how alerts and risks raised through the Clinical Board reports would be tracked over time, including how mitigating actions, progress updates and evidence of risk reduction would be reported to provide assurance that concerns were being effectively addressed.<br><br>JR noted the reporting process remained under development and that the Committee's focus should be on the assurance provided that risks were being managed appropriately, rather than the detailed operational issues themselves. JR acknowledged that future iterations of the reporting template should strengthen the tracking of issues over time.<br><br>JR advised that recent reports into maternity services in Nottingham and learning disability services in Muckamore would be reviewed through formal gap analyses by the relevant Clinical Boards.<br><br>RU expressed concern regarding the increasing complexity of complaints and asked what was driving this.<br><br>Angela Hughes (AH), the Assistant Director of Patient Experience, advised that complaint volumes had increased significantly, influenced by changes in the political landscape and the introduction of the new complaints process. Increasing complexity was largely driven by communication issues, discharge arrangements and the growing number of patients with health and social care needs spanning multiple services. It was noted that improving communication with patients could help reduce concerns, whilst wider system pressures are also contributing to the trend.<br><br>JR added that the increased use of technology and AI might be contributing to higher number of concerns raised.<br><br>RU emphasised that whilst technology might make it easier to submit complaints, the underlying concerns remained valid and should not be discounted. | |

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| | CP sought assurance that learning and good practice identified within Clinical Board reports was being shared and embedded across the organisation, ensuring opportunities for improvement are translated into practice and adopted more widely where appropriate.<br><br>AH emphasised the importance of learning from all complaints. Robust processes were in place to identify and implement learning from incidents, but further focus was needed on embedding lessons, demonstrating improvement, sharing learning with complainants, and identifying emerging concerns before harm occurs.<br><br>CP highlighted the opportunity for the Committee to promote organisational learning by identifying and sharing good practice across Clinical Boards.<br><br>**The Committee resolved that:**<br>A) The Clinical Board Highlight Reports were reviewed for assurance. | |
| **QC2 26/06/30/3.2** | **Annual Reports**<br><br><u>3.2.1 - Complaints, Redress and Inquests</u><br><br>AH presented the Annual Report on Complaints, Redress and Inquests, and highlighted the following:<br>• This was the final report prepared under the former Putting Things Right arrangements, following the introduction of the Listening to People framework from April 2026.<br>• Complaints, redress cases and inquests remained important sources of organisational intelligence, providing insight into patient experience, safety, service reliability and organisational risk.<br>• The UHB received 3,245 complaints during the reporting year together with 1,173 enquiries, with recurring themes relating to access, waiting times, communication and service capacity. Complaint volumes had continued to increase, with over 1,000 complaints received during the first quarter of 2026/27, representing a 57% increase compared to the same period in the previous year.<br>• The introduction of an enquiries service and an early resolution approach had resulted in approximately 55% of concerns now being managed through early resolution processes. This represented a significant increase compared to previous years and reflected a more proportionate and person-centred approach to complaint handling.<br>• Performance against statutory standards had remained strong and that robust governance arrangements were in place, supported by regular oversight meetings with Clinical Boards.<br>• Common learning themes continued to include communication, clinical assessment and decision-making, documentation, discharge planning, care coordination, compassionate care and system reliability.<br>• 212 inquests had been recorded during the reporting period, most of which had been categorised as low risk and managed through established arrangements.<br>• The organisation had received four Prevention of Future Deaths (PFDs) reports during the year, relating to estates issues, medication management, patient follow-up arrangements and risk information sharing. Learning arising from inquests was focused on improving evidence gathering, family communication, clinical decision-making and organisational learning.<br>• The UHB had developed a new Complaints Management System (CMS) to complement the Datix system and that the new system would provide greater visibility of demand, complaint themes, timeliness and pressure points and would enable more detailed thematic analysis to support organisational learning and improvement.<br>• Under the Listening to People framework there would be an increased emphasis on addressing concerns as close as possible to the point of care, promoting early engagement with patients and families, reducing duplication and ensuring complaints | |

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| | were used as a mechanism for learning and improvement rather than simply a process for case closure.<br><br>JRH commented that an increase in complaints should not necessarily be viewed negatively, as it could indicate that people felt able to raise concerns and access appropriate channels. Drawing on a personal experience, JRH welcomed the move towards more personalised responses under the Listening to People arrangements.<br><br>AH welcomed improvements introduced through the Listening to People process, noting that complaint responses were now more person-centred and proportionate. She emphasised that complaints should be viewed as valuable learning opportunities and highlighted the importance of engaging with communities who may not raise concerns, sharing learning from feedback, and capturing positive as well as negative patient experiences to support service improvement.<br><br>RU asked how the new CMS would enhance governance arrangements and support the identification of themes and organisational intelligence.<br><br>AH explained that whilst Datix would remain the Health Board's central repository for complaints data, the CMS would allow for more detailed categorisation and analysis of concerns. She advised that this would enable the UHB to identify more granular themes, strengthen learning and support service improvement activity.<br><br>**The Committee resolved that:**<br>a) The content of the Putting Things Right Annual Report 2025/26 was noted;<br>b) Assurance was taken that governance, oversight and operational arrangements were in place to manage concerns, complaints, redress and inquests in line with statutory requirements and support transition to the Listening to People Framework;<br>c) The visibility of organisational themes, trends, risks and emerging issues, and the arrangements in place to support escalation, learning and service improvement across Clinical Boards was noted;<br>d) The continued development of the CMS and associated governance processes to strengthen oversight, reporting, compliance and organisational learning was supported;<br>e) The clear forward plan for implementation of Listening to People was noted, supporting a more consistent and person-centred approach to engagement, resolution and learning. | |
| **QC2 26/06/30/3.3** | **Quality & Operational Risks (scoring 20-25)**<br><br>Frankie Ogden (FO), the Head of Corporate Governance, presented the report on Quality and Operational Risks, and highlighted the following:<br>• The purpose of the paper was to demonstrate the approach being implemented to improve the visibility and oversight of high-scoring risks across the organisation.<br>• 93 risks had been identified as quality and operational risks, forming a significant proportion of the approximately 190 risks scoring 20 or above currently recorded on the organisation's risk register on AMAT and noted that around 1,500 risks were recorded in total across the UHB.<br>• The proposed approach would align risks to relevant Committees, ensuring each receives oversight of risks within its remit, including quality, operational, workforce, reputational, digital and cyber risks.<br>• The UHB was now in a much stronger position following the implementation of a single risk management system, enabling risks to be viewed, scrutinised and monitored consistently across the organisation.<br>• This provided greater opportunity to identify risks driving quality concerns and would help inform organisational decision making. Further work remained ongoing to review and moderate risks, particularly within Clinical Boards, to ensure consistency in risk scoring and descriptions. | |

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| | JR commented that the focus now was on embedding risk management as a live, ongoing process across the organisation, ensuring risks were consistently identified, reviewed and escalated.<br><br>RU asked how the Committee would be able to track movement in risks over time and identify where risks had improved, deteriorated or remained unchanged between meetings.<br><br>FO explained that the information would become a standing feature of Committee reporting and would be discussed regularly throughout the year. She advised that the reports generated from AMAT provided significantly more detail than had previously been available and that there was ongoing work to integrate risk management with the Quality Management System (QMS) and wider performance management arrangements.<br><br>**The Committee resolved that:**<br>a) The approach being implemented to align high-scoring (20+) organisational risks to Committee structures, improving visibility and governance oversight across all remits was noted;<br>b) The development of a consistent, organisation-wide approach to risk reporting and discussion within Committees, including integration into forward plans and routine agenda items, was supported. | |
| | **Strategic Portfolio: <u>Providing Outstanding Quality</u>** | |
| **QC2 26/06/30/4.1** | **Board Assurance Framework (BAF)**<br><br>FO introduced the Board Assurance Framework (BAF) which was presented for initial awareness, with future items focusing on specific areas within the BAF for more detailed scrutiny. These would be incorporated into the Forward Plan for ongoing oversight throughout the year.<br><br>CP asked whether trend reporting could be standardised, including the potential use of SPC charts, to improve the clarity and consistency of data presentation and interpretation.<br><br>FO responded that these conversations were ongoing to try and present the information in a clearer and more consistent format.<br><br>CP raised concern that several actions showed overdue completion dates without providing a current status update.<br><br>FO explained that tracked versions of the BAF usually included status updates and confirmed that future reports would provide greater visibility regarding progress and completion status.<br><br>**The Committee resolved that:**<br>A) The BAF was noted for assurance. | |
| **QC2 26/06/30/5** | **Shaping our Population Health and Place-Based Partnerships**<br><br>*No items.* | |
| **QC2 26/06/30/6.1** | **Shaping our Quality, Value & Sustainability**<br><br><u>6.1.1 - Update on Fuller Report recommendations</u><br><br>Helen Luton (HL), the Interim Director of Nursing CD&T, presented an update on progress against the recommendations arising from the Fuller Inquiry, and highlighted the following:<br>• The paper focused on the 21 recommendations relevant to NHS mortuary services and outlined the work undertaken locally to assess compliance and implement the necessary improvements. | |

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| | • A detailed gap analysis had been completed against the recommendations and that seven of the 21 recommendations had been fully implemented, with the remaining actions largely on track.<br>• Some outstanding actions were dependent upon capital investment and support from Estates and Facilities colleagues, whilst others required national changes to All-Wales procedures.<br>• The UHB had recently undergone a Human Tissue Authority (HTA) inspection and had achieved compliance with all required standards.<br>• Key updates were provided in relation to the mortuary estate and security and access arrangements. CCTV systems, access controls and monitoring arrangements had been strengthened following previous refurbishment works of the UHB mortuary, with routine audits now undertaken to ensure access permissions remained appropriate. Further improvements were required to fully meet recommendations relating to access controls and CCTV coverage but were working closely with Estates colleagues.<br>• The UHB's temporary body store at University Hospital Llandough (UHL) had been decommissioned following publication of the recommendations, as it did not fully meet the revised requirements. Additional mortuary capacity had been created elsewhere within the UHB, and further work was underway to ensure sufficient compliant capacity was available to support winter pressures.<br>• In relation to safeguarding, full compliance with recommendation 19 would require amendments to All-Wales safeguarding procedures and training materials. However, discussions were already underway with safeguarding colleagues to identify interim arrangements that could strengthen compliance locally.<br>• Requirements around governance and reporting were highlighted, as recommendations reflated to board reporting arrangements for mortuary services as a regulated area. Locally they had a HTA Compliance Group which reported into CD&T Quality & Safety meetings.<br><br>CP sought assurance regarding the interim arrangements in place whilst the temporary body store in UHL was out of use.<br><br>HL responded that the temporary UHL body store was taken out of use following recommendations received. Additional mortuary capacity was created within the UHB and proved sufficient over the winter, but further contingency capacity was being explored to manage potential seasonal pressures whilst ensuring compliance with security and CCTV requirements.<br><br>**Provide a formal report to the Committee on mortuary activities – ACTION.**<br><br>**The Committee resolved that:**<br>a) The evidence of substantial progress against the 21 Fuller recommendations was noted;<br>b) The residual risks relating to body storage capacity, capital-dependent security controls and safeguarding training was acknowledged;<br>c) Arrangements for future reporting into appropriate Board / Committee was confirmed;<br>d) A further update once capital estimates, winter capacity plans were confirmed was supported. | |
| **QC2 26/06/30/7.1** | **Shaping our Future Clinical Services**<br><br><u>7.1.1 - Cardiac Implant Update</u><br><br>David Hanna (DH), the Clinical Board Director – Specialist Services, presented an update on the Cardiac Devices Service, and highlighted the below:<br>• The service was a high-volume, safety-critical service, supporting approximately 10,000 patients under routine follow-up and around 800 new implants each year | |

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| | • Concerns had first been raised during 2024 through staff feedback, Datix reporting and a wider review of Adult Cardiology services.<br>• Initial concerns related to eight patients receiving devices beyond their expiry date and a separate cohort of patients who had reached battery depletion before device replacement. Whilst investigations found minimal or no harm in the former group, both issues highlighted weaknesses in administrative processes, scheduling arrangements and service capacity. A multidisciplinary working group had subsequently been established to oversee investigations, validation work and service improvements.<br>• As further reviews were undertaken, additional risks were identified, including capacity constraints, reliance on manual Excel-based tracking systems, inappropriate removal of patients from follow-up lists following non-attendance, weaknesses in remote monitoring arrangements, disconnected home monitoring systems affecting approximately 600 patients, and incorrect alert settings affecting around 800 patients.<br>• A Coroner's Regulation 28 case and an NRI investigation relating to concerns about whether missed opportunities for clinical intervention had contributed to patient harm were highlighted.<br>• Actions underway over the past 12 months included validating patients removed from follow-up after a DNA, with high-risk cohorts completed and lower-risk cohorts ongoing. Work continued to validate missed alerts, while all patients affected by unconfigured alerts have been notified, with only 22 of 800 still awaiting device reconfiguration. Clinical governance had been strengthened through improved Datix reporting, patient safety learning processes, and a response to the coroner's Regulation 28 request. Service improvements included new SOPs, a more clinically led outpatient booking process to reduce loss to follow-up, enhanced stock control through Scan for Safety, and implementation of the Fysicon patient management system to improve oversight and data quality.<br>• Investment and service development work was underway to improve leadership, governance and workforce capacity. This included recruitment to a senior Cardiac Physiology Professional Lead role, development of a dedicated remote monitoring function, ring-fenced education and training time for physiologists, enhanced quality management arrangements and development of KPI dashboards and governance reporting processes.<br><br>Claire Beynon (CB), the Executive Director of Public Health, sought assurance regarding whether the identified issues could recur in the future.<br><br>DH responded that whilst risk could never be completely eliminated within such a complex service, substantial progress had been made, and the service was considerably safer than it had been previously.<br><br>Peter O'Callaghan (POC), the Consultant Cardiologist and Heart Rhythm Specialist, noted that although the service had improved significantly, further work remained necessary to ensure it reached the required standard. He highlighted the need for continued attention to administrative support, workforce resilience, leadership and capacity.<br><br>Jessica Castle (JC), the Director of Operations – Specialist Services, commented that one of the most significant improvements had been the positive change in organisational culture within the service. Staff were now more willing to raise concerns openly, report risks and engage in governance processes, which contributed significantly to service improvement. JC also highlighted the importance of protected time for quality, safety, education and professional development.<br><br>RU asked how physiological findings and clinical symptoms would be integrated to ensure a holistic, patient-centred approach, avoiding siloed care and ensuring all aspects of treatment and monitoring worked cohesively. | |

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| | DH responded the service was shifting towards a more holistic model of care, with staff encouraged to identify and respond to wider patient needs. New SOPs, clinical assessments at device review appointments, and strengthened governance, monitoring and quality management arrangements were intended to support a more integrated, patient-centred and resilient service.<br><br>POC noted physiologists were highly trained and supported by named cardiologists for each patient. Following lessons from the coroner's case, communication was moving from email to an e-advice system within the Welsh Clinical Portal (WCP), improving integration, record-keeping and access to specialist cardiology support when required.<br><br>Emma Cooke (EC), the Executive Director of AHPs, Health Scientists and Community Services Development, noted that the new service lead would focus on workforce development, increasing advanced training and HCPC registration to strengthen workforce capability and resilience.<br><br>RU asked how the new e-advice system would support documentation and learning within clinical records, and whether multidisciplinary case reviews or grand rounds were being used to share learning and promote collaborative practice across cardiology services.<br><br>POC responded that learning from cases was routinely discussed through Quality & Safety forums. Regarding e-advice, a pilot was being developed to record communications between psychologists and cardiologists within the WCP, improving documentation and information sharing.<br><br>DH added that there was always a cardiology registrar and consultant on call, ensuring physiologists could access timely specialist advice and support whenever clinical concerns arose.<br><br>JRH asked about the timescales for the remaining improvements, whether additional support or investment would be required and how the Committee would continue to monitor progress.<br><br>DH responded that as risks were investigated, further issues emerged, requiring prioritisation of the highest-risk patients and actions. Immediate patient safety concerns had largely been addressed, with current efforts focused on embedding sustainable improvements. Further investment in leadership, skills and capacity may be required to achieve the desired standard of care, supported by robust service planning and governance arrangements.<br><br>JR asked whether the cardiology service was able to reliably identify risks moving forward.<br><br>DH responded that significant improvements had been made to the cardiac devices service through strengthened risk management, use of AMAT and development of a multidisciplinary QMS. While the service was in a much stronger position than previously, further work was required to address remaining risks and continue service improvement.<br><br>JR reflected that many of the themes identified within the review including governance, workforce sustainability, capacity, follow-up arrangements and risk management, were relevant across a number of clinical services. He suggested that the learning arising from this work should be considered more broadly across the organisation.<br><br>DH added that learning from this work highlighted that relying solely on nationally reported metrics could leave important risks unidentified. In response, the service was developing a QMS with locally defined quality measures to strengthen oversight and risk identification at service level. | |

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| | **Return to the Committee in six months with an update on progress and assurance regarding the cardiac devices service improvements – ACTION.**<br><br>**The Committee resolved that:**<br>a) The progress made in reviewing the service and addressing patient safety risks was noted;<br>b) Ongoing system risks across workforce, governance and digitisation and current mitigations in place were acknowledged;<br>c) Continued transformation programme delivery was supported;<br>d) Progress with reviewing workforce models of delivery and demand/capacity review, digital transformation and administrative capacity, systems and processes were noted. | |
| **QC2 26/06/30/7.2** | 7.1.2 - Ophthalmology review update<br><br>Catherine Wood (CW), the Deputy Chief Operating Officer, presented an update on the Ophthalmology Improvement Programme, and highlighted the below:<br>• Ophthalmology services, particularly the Age-Related Macular Degeneration (AMD) pathway, had been subject to scrutiny over the previous two years due to concerns regarding service sustainability, waiting times and patient safety.<br>• Intensive improvement work had been undertaken over the last 18 months, supported by strong clinical leadership and oversight from the Chief Operating Officer and Executive Team.<br>• Substantial progress had been made within the AMD pathway. The previous backlog of approximately 2,600 patients had been eliminated, the pathway had been stabilised, and a sustainable service model had been established. Harm reviews had been completed for patients within the lost-to-follow-up cohort, and a dedicated fail-safe officer had been appointed to strengthen compliance with Royal College guidance.<br>• Changes to the treatment pathway and the introduction of alternative medication regimens had enabled patients to be treated more efficiently whilst increasing capacity and improving the sustainability of the service.<br>• In relation to glaucoma services, a bespoke Glaucoma Diagnostic Unit had been established at UHL. Alongside this, they implemented the Welsh General Ophthalmic Services pathways for monitoring patients in the community and has meant 56% of their patients are now receiving care outside of a hospital setting.<br>• CAVUHB led Wales in delivering high-volume cataract surgery at UHL, meeting GIRFT and ministerial requirements. Routine lists now delivered 7-8 cases per session, supported by a clear expansion plan that had significantly reduced long waits for cataract treatment across the UHB and region.<br>• A range of digital improvements had been made, including the full implementation of the OpenEyes electronic patient record system and the introduction of an electronic referral process in June 2026. These developments had strengthened governance arrangements, improved patient tracking and reduced the risk of patients being lost within pathways.<br>• Workforce and succession planning arrangements had been strengthened through new appointments and recruitment activity across several specialist areas. Focus had been given to roles supporting patient safety, governance and pathway management.<br>• Outpatient waiting lists had reduced significantly, with the number of patients waiting over 104 weeks falling by approximately 90%.<br>• The service had moved from a position of significant fragility to one which was considerably more sustainable and better equipped to manage future demand.<br><br>David Fluck (DF), the Executive Medical Director, noted that whilst further work was needed to embed the use of the electronic systems across all teams, significant process had been made. | |

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| | **Provide a further update to the Committee in six months on further progress in Ophthalmology service transformation and electronic system engagement – ACTION.**<br><br>CP suggested that the cataract service and wider surgical hub development be promoted more widely, including consideration of a ministerial visit.<br><br>**The Committee resolved that:**<br>A) The update was noted. | |
| | **Policies for Approval** | |
| **QC2 26/06/30/8** | *No policies for approval.* | |
| | **Items for Noting / Information** | |
| **QC2 26/06/30/7.2** | **Safeguarding Steering Group (SSG) Highlight Report**<br><br>The Safeguarding Steering Group (SSG) Highlight Report was received.<br><br>**Arrange for a presentation / report on Mental Capacity Act (MCA) and consent training to be brought to the Quality Committee – ACTION.**<br><br>**The Committee resolved that:**<br>a) The Safeguarding Steering Group (SSG) Highlight Report was noted. | |
| **QC2 26/06/30/9.1** | **Infection Prevention & Control (IPC) Group Highlight Report**<br><br>The Infection Prevention & Control (IPC) Group Highlight Report was received.<br><br>**The Committee resolved that:**<br>A) The Infection Prevention & Control (IPC) Group Highlight Report was noted. | |
| | **Items Needing Escalation to Board** | |
| **QC2 26/06/30/9.2** | CB asked if the Cardiac devices item needed to be received by the Board.<br><br>CP advised that it would feature in the Quality Committee Chairs Report at the next Board meeting in July 2026. | |
| | **Any Other Business** | |
| **QC2 26/06/30/12** | *No other business was raised.* | |
| | **Review of the Meeting** | |
| **QC2 26/06/30/13** | *Committee members were asked to fill out the Committee Self-Effectiveness survey.* | |
| | **Date & Time of Next Meeting:** | |
| **QC2 26/06/30/14** | *28th July 2026 at 9am via MS Teams* | |

| Title | Minute Reference | Agreed Action | Executive Lead | Action Lead | Date Assigned | Date for Review | Action Status | Action Update |
|---|---|---|---|---|---|---|---|---|
| ePMA Programme Trajectory and Data | QC 2026/04/2.1 | For data demonstrating the impact of ePMA on patient safety and quality be circulated to the Committee. | Jason Roberts | Rhodri Clyburn & Elaine Lewis | 14/04/2026 | 14/09/2026 | IN PROGRESS | Once data has been circulated to Committee Members, this action can be marked as Complete.<br><br>EL update 15/07/2026 - the data analyst has just started, so data should be available in a few weeks. |
| Theatres Together Programme | QC 2026/06/3.4.1 | Confirm timeline for restoring theatre performance data reporting and for further detail on the descoped action within the Theatres Together Improvement Plan to be circulated outside of the Committee. | Catherine Wood | Catherine Wood | 02/06/2026 | 29/09/2026 | IN PROGRESS | Theatre Data Reporting went live at the start of July 2026.<br><br>Further detail on the descoped action within the Theatres Together Improvement Plan to be circulated in advance of the 29th September 2026 Quality Committee. |
| Cardiac Implant Update | QC2 26/06/30/7.1 | Return to the committee in six months with an update on progress and assurance regarding the cardiac devices service improvements. | Catherine Wood | David Hanna | 30/06/2026 | 01/12/2026 | ON FORWARD PLAN | Added to the Quality Committee Forward Plan for the 1st December 2026 meeting. |
| Update on Fuller Report recommendations | QC2 26/06/30/6.1 | Provide a formal report to the committee on mortuary activities, including updates against Fuller recommendations, activity, and any HTA incidents. | Jason Roberts | Helen Luton | 30/06/2026 | 27/10/2026 | ON FORWARD PLAN | Item added to the Forward Plan for the 27th October 2026 Quality Committee meeting. |
| Ophthalmology review update | QC2 26/06/30/7.2 | Provide a further update to the Committee in six months on further progress in Ophthalmology service transformation and electronic system engagement. | Paul Bostock | Catherine Wood | 30/06/2026 | 26/01/2027 | ON FORWARD PLAN | Item added to the Forward Plan for the 26th January 2027 Quality Committee meeting. |

| CLINICAL BOARD QUALITY UPDATE REPORT | | | |
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| **Governance Group:** | Medicine | **Date of Meeting:** | July 2026 |
| **Representative at Clinical Board Governance:** | | **Date of Meeting:** | |

| ITEMS FOR ALERT | | |
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| **Issue / Risk** | **Actions Taken** | **Group Responsible** |
| A significant number of unreported endoscopy reports have been identified, raising concerns that patients may not have received their results or been offered the recommended follow-up in accordance with national guidelines. | • A retrospective review is currently being undertaken to assess whether any patients experienced harm as a result of delays in the processing and management of diagnostic results.<br>• The issue has been escalated to both the Clinical Board and Executive Team for oversight and assurance.<br>• An Executive Warning Notice (EWN) and Nationally Reportable Incident (NRI) report are being progressed in accordance with organisational governance and reporting requirements | Specialised Medicine MCB/CORP EXECS. |
| The diabetes service is currently unable to robustly start a hybrid closed loop pump service as recommended through NICE guidelines with approximately 1200 patients on the waiting list | • A limited service is being run to support high risk clinical patients and long wait patients<br>• Paper submitted to VBRG to be sighted on business case and organisational ask<br>• Issue raised through Clinical Board and Executive Team for oversight and assurance.<br>• Held on AMAT and recorded as organisational risk<br>• Diabetes service overall is being reviewed to try and identify any potential efficiencies to support a more robust pump service | Integrated Medicine MCB and CORP EXECS |

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| | • Business case has been submitted to support a sustainable service but is reliant on funding and not fully approved | |
| Endoscopy services are currently reliant on Insourcing to manage cancer and surveillance position | • Consultants are being engaged in WLI activity to reduce reliant on insourcing<br>• An action plan is in place to look at booking systems, validation and administrative processes to reduce demand<br>• Alternative pathways are being used and developed such as capsule sponge endoscopy to try and improve productivity and efficiency in list management | Specialised Medicine MCB/CORP EXECS. |
| DXA Scan Clinical Interpretation backlog of GP referred patients<br>Growing backlog of DXA scan reports requiring clinical interpretation currently 800 with approx. wait of 19 weeks<br>Net growth backlog of approx. 170 scans per month<br><br>Clinical Impact<br>· Delay in diagnosis and clinical management of osteoporosis<br>· Delay or omission of treatment<br>· Increased risk of fragility fractures (hip, vertebral, wrist)<br>· Potential harm to vulnerable patient groups<br>· Risk that it is not feasible to authorise an ionising radiation exposure due GP lack of knowledge to interpret results without clinical report, which is taking excessive time.<br>· Risk of overlooked incidental findings with potential clinical significance | • Previously these were reported by an individual clinician who has retired.<br>• Formal process being reviewed with PCIC and CDT in terms of passing these back to requestor<br>• Short term additional clinician capacity being created<br>• Referral guidance within primary care<br>• Staff training<br>• Medical physics exploring a fully integrated inhouse DXA service | Integrated Medicine MCB PCIC and CDT |

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| Patient Experience<br>· Prolonged anxiety while awaiting results<br>· Repeated GP follow-ups querying missing reports<br>· Loss of confidence in diagnostic services | | |
| High numbers of patients with prolonged lengths of stay continue to present a significant patient safety and quality concern. Extended hospitalisation increases the risk of deconditioning, loss of independence, healthcare-associated infections, falls, pressure damage and poorer patient outcomes, whilst also impacting patient flow, capacity and timely access to care across the Health Board. | • Improvement work in progress utilising the exemplar ward programme -currently have 2 wards within MCB that are part of this programme prior to a full roll out across MCB – part of this work will be implementing DEWI (Deconditioning Early Warning Indicator) | Programme Manager/MCB |
| Capacity constraints with access to inpatient beds results in medical patients being 'outlied' to surgical and specialist beds. This impacts on capacity in those clinical areas but also leads to poor experience for those patients outlied, who experience a longer length of stay and reduced access to specialist care from medical specialities. | • Changes to the acute pathway and acute model should improve capacity for all medical patients to be managed with in the dedicated bed base. Improvements in LOS will also improve capacity for medical inpatient beds. | MCB |

| **ITEMS TO ADVISE** | | |
|---|---|---|
| **Issue / Risk** | **Actions Taken** | **Group Responsible** |
| Nationally Reported Incidents- The current NRI position remains a concern, with six incidents overdue; however, there is evidence of improvement, with five cases nearing closure. Oversight has been strengthened to support timely progression, with continued monitoring through governance processes. | • The overall position continues to demonstrate sustained improvement, with seven overdue Nationally Reportable Incidents (NRIs) scheduled for | Director of Nursing/MCB QSE Leads |

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| | closure during July 2026, including four cases being addressed as part of a thematic review. A targeted improvement programme remains in place to reduce the backlog, incorporating a traffic light monitoring system to track progress, weekly oversight meetings with the Director of Nursing, and direct engagement with reviewers to facilitate timely completion of investigations. | |
| Dermatology pathways continue to experience capacity constraints across both outpatient assessment and surgery. This results in delays to treatment for some patients particularly with relatively low risk vasal cell carcinoma requiring excision. There are also some delays and issues with reporting of histopathology specimens and related problems in post-operative follow-up of patients to inform them of results and next steps of treatment. In a small number of cases this has contributed to | • The immediate patient safety risks are being actively managed through ongoing clinical review and governance processes. However longer-term mitigation will require | The dermatology directorate with direct support from MCB triumvirate. |

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| patients not receiving planned follow-up within expected timescales, creating clinical governance concerns and leading to an NRI.<br><br>Although teledermatology is successful managing demand by reviewing referrals remotely and discharging approximately 40% of patients without face-to-face attendance, the current service model has not translated into a reduction in outpatient clinic activity or released capacity elsewhere in the pathway. As a consequence increasing demand continues to outstrip available capacity.<br><br>There are opportunities to strengthen clinical governance arrangements, improve consistency of clinical pathways and reduce unwarranted variation in practice. The current service model has evolved over time and there some redesign of pathways is required to improve alignment of workforce with outpatient activity, teledermataology, and surgical capacity.<br><br>. | significant redesign.<br>• Discussions for support of the NHS P&I leads for outpatient improvement have been commenced.<br>• Further work required to fully evaluate:<br>• -Sustainable operating model for teledermatology that release outpatient activity.<br>• -Implement a risk based follow-up protocol to ensure surveillance is clinically appropriate whilst avoiding unnecessary outpatient appointments.<br>• -Improve tracking and governance of patient requring post op followup<br>• -Agree single standardised dermatology pathway across referral, assessment, treatment and follow-up. | |

| ITEMS FOR ASSURANCE | | |
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| **Issue / Risk** | **Actions Taken** | **Group Responsible** |

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| RECENT LEARNING OPPORTUNITY | | | |
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| **Source:** | MCB QSE Meeting | **Reference (if applicable):** | |

**What happened / what was the problem?**

A patient story was recently heard at Junes MCB Q&S Meeting. This case highlights significant concerns raised by a family regarding a patient's care on an Integrated Medicine ward at UHW. They described poor communication, inadequate involvement of the patient in decision-making, inconsistent recognition of deterioration, and multiple gaps in fundamental nursing care. Concerns were also raised about dignity and respect, infection prevention practices, and the communication and management of end-of-life care, leaving the family feeling unprepared and distressed. While the patient's experience on the ward was reported as complex and at times distressing, the family noted a marked improvement in care following transfer to another ward, suggesting inconsistency in standards across clinical areas.

**What was learned and how was this shared?**

This case emphasised the importance of providing compassionate, patient-centred care through clear communication, active involvement of patients and families in decision-making, and timely recognition of deterioration. It highlights the need to maintain high standards of fundamental care, dignity, respect and consent, alongside effective continuity and handover processes. The case also reinforces the importance of sensitive, proactive end-of-life discussions and the need to reduce variation in care quality to ensure a consistently positive patient and family experience across all wards.

Learning from this case was shared through ward team discussions, safety huddles, governance and quality meetings, and dissemination of key learning points to nursing and medical staff. Themes relating to communication, recognition of deterioration, fundamental care, dignity and respect, infection prevention, and end-of-life care were incorporated into reflective practice to promote improvement and reduce the risk of recurrence.

**What action has been taken or planned? What was the impact of this?**

In response to the concerns identified, a range of improvements have been implemented focusing on communication, recognition of deterioration, fundamental care, dignity and respect, infection prevention, and end-of-life care. Actions included reinforcing communication and consent practices, improving handovers and family engagement, enhancing training on observations, documentation and medication safety, strengthening IPC compliance, and promoting earlier palliative care involvement. Learning from the patient's experience was shared with staff through reflection, team learning and quality forums like MCB QSE, supporting a culture of compassion, safety and continuous improvement across the organisation.

The actions implemented have strengthened patient-centred communication, improved staff awareness of the importance of involving patients and families in care decisions and reinforced the value of listening to concerns about deterioration. Reminders regarding documentation, observations, medication safety, patient identification, dignity and respect have supported safer and more consistent fundamental care. Increased focus on infection

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prevention and earlier involvement of palliative care teams have improved both patient safety and end-of-life care experiences. Sharing the patient's story through reflection and learning forums has also helped promote a culture of compassion, accountability and continuous improvement, while reducing variation in care standards across wards.

## HIGHLIGHTS OF GOOD PRACTICE TO SHARE

A Standard Operating Procedure (SOP) has been developed to support all Quality, Safety and Experience (QSE) activities across the Medicine Clinical Board. The SOP has been discussed at recent QSE meetings and has now been approved for dissemination. This SOP sets out the governance arrangements within each Medicine Clinical Board (MCB) Directorate and defines the roles, responsibilities, scope and processes associated with key quality and safety functions. It includes guidance on:

- Quality, Safety and Experience (QSE) meetings
- Mortality and Morbidity (M&M) reviews
- National Reportable Incidents (NRIs)
- Concerns management
- Coroner-related processes
- Datix incident reporting
- Risk management
- Promoting wellbeing, culture and psychological safety

The aim is to support effective governance, strengthen oversight and assurance processes, and drive continuous improvement across our services.

## OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

| Case No | Action | Due Date | Reason for Non Delivery | Risk (RAG) |
|---|---|---|---|---|
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## NEW / CLOSED / AMENDED RISKS

| CLINICAL BOARD QUALITY UPDATE REPORT | | | |
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| **Governance Group:** | SCB QSE | **Date of Report:** | 16th July 2026 |
| **Representative at Clinical Board Governance:** | Clare Wade | **Date of Meeting:** | 28th July 2026 |

| ITEMS FOR ALERT | | |
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| **Issue / Risk** | **Actions Taken** | **Group Responsible** |
| Increase in *Clostridioides difficile* cases in April 2026, following a sustained period of low incidence | A detailed review of the April 2026 cases has been commissioned to identify contributory factors, emerging themes and opportunities for learning. This will return to SCB IPC in July 2026 for formal review of findings, agreement of any required actions and confirmation of how learning will be shared across the Clinical Board. Ongoing assurance will be provided through IPC governance routes, with themes monitored for recurrence and escalated where further controls are required. | Infection Prevention and Control / Clinical Board |
| Estates and environmental issues are impacting infection prevention and control, including ward bathroom conditions raised through HIW feedback. | The environmental audit process has been strengthened to include bathroom areas, supported by peer review audits and clarified escalation expectations. This provides greater assurance that environmental concerns are identified consistently, acted on promptly and escalated through nursing, estates, housekeeping and IPC routes where remedial action is required. Findings will continue to be monitored through local quality and safety arrangements to evidence completion of actions and identify any recurring themes. | Nursing Leadership / Estates / Housekeeping |
| Wrong implant opened and inserted during right femoral shaft fracture procedure. A left-sided TFNA nail was opened and implanted before being identified under fluoroscopic imaging. This meets the threshold for Never Event/NRI review and requires wider safety alerting. | The incorrect implant was identified intra-operatively, removed and replaced with the correct implant. A Datix was submitted on 14/07/26 and a rapid review has commenced to identify immediate learning, contributory factors and any wider control gaps. The patient and husband were informed through a Duty of Candour discussion on 14/07/26, which is documented in the clinical record. A PSLR will be completed jointly by the Clinical Board Director and Director of Nursing, with findings and actions to be reported through Surgical Clinical Board Quality and Safety Governance. Immediate assurance includes confirmation of intra-operative correction, open disclosure, incident reporting, senior clinical oversight and planned wider learning/escalation across peri-operative and trauma and orthopaedic services. | Peri-Operative Services; Trauma and Orthopaedics; Patient Safety Team; Surgical Clinical Board Quality and Safety Governance. |

| ITEMS TO ADVISE | | |
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| **Issue / Risk** | **Actions Taken** | **Group Responsible** |

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| Perioperative ketone monitoring protocol for patients receiving SGLT2 inhibitors. A new clinical pathway has been developed and presented, with support from Anaesthetics, Pharmacy, and Diabetes teams. The Clinical Board is supportive of implementation, subject to confirmation of governance hosting arrangements. | Advice has been sought from the UHB Governance Team regarding the most appropriate location for formal hosting of the pathway. This provides assurance that the pathway will be subject to appropriate organisational governance, document control, clinical ownership and review arrangements prior to implementation. Once the governance route is confirmed, implementation will be progressed with Anaesthetics, Pharmacy and Diabetes teams, with any required monitoring, education and escalation arrangements agreed through the relevant Clinical Board and UHB governance routes. | Clinical Board / UHB Governance Team |
| Paediatric thromboprophylaxis and VTE risk assessment protocol for 13–17-year-old patients admitted to Children's Hospital for Wales (CHFW). | Protocol added for Clinical Board awareness and assurance. The pathway sets out clear requirements for assessment of VTE risk factors and bleeding risk/contraindications, includes defined outcome options for no treatment, mechanical prophylaxis and enoxaparin, and requires reassessment at 48 hours, 72 hours and if the clinical condition changes. Enoxaparin guidance states 0.5 mg/kg twice daily, with renal discussion required where creatinine clearance is 15–30 ml/min. Assurance is provided through use of a standardised risk assessment process, defined reassessment points, clear prescribing guidance and escalation requirements for renal impairment, supporting consistent decision-making and safer thromboprophylaxis practice across CHFW pathways. | Thrombo-embolic Prevention and Treatment Group / CHFW / Clinical Teams |
| Hypoglycaemia SBAR has been developed within SCB is due for Nursing and Midwifery Board review, seeking approval for a formalised UHB process for adult inpatient hypoglycaemia box checks. | The SBAR describes variation in how hypoglycaemia boxes are checked, stocked and understood by staff, and proposes a consistent UHB process supported by revised Tendable audit questions. Proposed monthly audit scoring includes daily checks completed, 1–2 missed checks, or 3 or more missed checks in the previous full calendar month. This strengthens assurance by introducing a consistent monitoring mechanism, clearer compliance thresholds and routine visibility through Tendable reporting. Results will support ward-level ownership, escalation where repeated missed checks are identified and oversight through nursing, diabetes and Clinical Board governance arrangements. | Nursing and Midwifery Board / Diabetes Nursing Team / Clinical Boards |
| Theatres Together July project board and WG update material provides further assurance and update on workstreams across people, | The update identifies progress across the programme, including closure of the Foundation Tranche, progress within | Theatres Together Project Board / |

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| culture and workforce; cleaning standards; HSDU; scrubs; and theatre efficiency. | Embedding Culture and High Impact workstreams, continued work on cleaning standardisation, HSDU engagement and survey activity, scrubs/laundry improvement actions, and theatre efficiency metrics with a focus on start times, overruns, utilisation, on-the-day cancellations and turnaround time. Assurance is provided through Project Board oversight, workstream reporting, action tracking, dashboard development and continued risk and issue review. This demonstrates a structured delivery framework, with progress monitored against agreed workstreams and escalation routes in place where delivery risks, dependencies or recurrent performance issues are identified. | Perioperative Directorate |
| The inquest into the death of a patient in Ocotber 2026 post operatiey has now concluded, with the Coroner considering the clinical care provided and the circumstances surrounding the patient's pathway. The Health Board fully supported the inquest process, providing evidence and engaging openly to ensure that all relevant factors were examined. Any learning identified has been incorporated into existing improvement plans and governance arrangements to strengthen patient safety and reduce the risk of recurrence. | **Clinical responsibility in recovery must be clear and documented.** The responsible anaesthetist should retain overall responsibility until the patient is stable, able to maintain their airway and communicate, or until care is formally handed over to another named clinician.<br>**Handover must be explicit, timely and recorded.** Any transfer of responsibility, assessment, clinical decision-making and escalation must be clearly documented in the patient record.<br>**Abnormal blood gas results must be actively reviewed, communicated and escalated.** The review identified the need for clearer responsibility for recognising, interpreting and acting on POCT/ABG results, particularly where tests are undertaken by non-medical staff.<br>**POCT systems require standardisation and governance.** Variation in blood gas analyser configuration, reference ranges and alert flags created risk; standardised devices, alert thresholds, training and quality assurance processes have now been strengthened.<br>**Staff must work within their competence.** Non-medical professionals undertaking blood gas testing must not independently interpret or act on results unless trained, assessed as competent and authorised; results requiring clinical interpretation must be escalated promptly.<br>**Delayed recovery of consciousness requires a systematic approach.** A structured assessment process is required for patients who do not wake as expected, ensuring | SCB QSE |

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| | reversible causes such as hypoglycaemia are actively considered and investigated.<br>**Documentation is central to patient safety and accountability.** Clinical records must clearly evidence assessments, decisions, escalation, communication, handover and actions taken; poor documentation weakens continuity of care and retrospective assurance.<br>**Medicines safety controls must be robust in theatre environments.** High-risk medicines, including insulin and local anaesthetics, require clear storage, checking, prescribing, administration and documentation arrangements.<br>**Theatre safety processes must be consistently followed.** WHO Checklist compliance, including full team Sign Out before staff leave theatre, is essential to support shared accountability, communication and patient safety.<br>**Human factors must be mitigated through system controls.** Workload, fatigue, interruptions and staff changeovers should be managed through clear protocols, escalation routes, two-person checks, and auditable records rather than reliance on individual vigilance alone.<br>**Medical photography and surgical video require strong information governance.** Clinical images must be securely stored, used only for appropriate purposes, and not used for teaching or wider purposes without appropriate consent.<br>**Ongoing assurance is required.** Learning must be embedded through training, audit, monitoring, incident review, governance oversight and escalation where compliance gaps are identified | |

| ITEMS FOR ASSURANCE | | |
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| **Issue / Risk** | **Actions Taken** | **Group Responsible** |
| Quality of MRSA root cause analysis and multidisciplinary engagement. | A high-quality review was completed and shared as an example of good practice, with strong multidisciplinary clinical engagement demonstrated throughout. | Infection Prevention and Control / Clinical Teams |
| Abscess pathway audit and re-audit demonstrate improvement following pathway development, morning Hot Clinic appointments, SNP training and use of | Initial audit identified 74 patients; re-audit identified 76 patients. Re-audit showed a higher proportion managed under local anaesthetic and a lower | General Surgery / SDEC / SNP Team |

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| Penthrox. | proportion requiring CEPOD. Penthrox was used successfully in 7 cases with no readmission or repeat procedure reported. Average waiting times reduced across all intervention groups, although the audit standard has not yet been achieved. | |
| Theatres Together continues to demonstrate structured governance and delivery through a tranche-based programme, project board oversight, workstream reporting and action tracking. | Programme updates describe continued positive movement from in-progress to completed recommendations, with Foundation closed, High Impact showing strong momentum, and Embedding Culture progressing across leadership, culture, education and theatre efficiency. Workstreams are being monitored through project board, scrum activity, action logs, dashboard development and risk/issue review. | Theatres Together Project Board / Shaping Change / Perioperative Directorate |
| Theatre efficiency improvement work is moving into a more data-led phase, with metrics agreed and improvement activity focused on start-of-day processes and list planning. | Efficiency metrics include starting on time, avoiding overruns, list utilisation, on-the-day cancellations and patient turnaround time. Current focus is development of the theatre efficiency/productivity dashboard, use of available Aqua data, specialty-specific improvement actions and a data-driven action plan focused initially on improving start times and the 6-4-2 process. | Theatres / Directorate Teams / Information Team / Shaping Change |
| Standardised cleaning workstream has a defined delivery plan and supports infection prevention, safety, clarity and consistency across theatre suites. | Project updates note that the cleaning equipment list has been finalised, checklists/posters/guidance are drafted or complete, staff and training arrangements are being developed, and a pilot/rollout approach is planned. Identified risks include resistance to standardisation, capacity/time pressures and clarity over cleaning products and standards, with IPC and supplier input ongoing. | Cleaning Standards and Policy Task and Finish Group / IPC / Theatres |

## RECENT LEARNING OPPORTUNITY

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| **Source:** | Concern | **Reference (if applicable):** | |

**What happened / what was the problem?**

.A patient raised a formal concern about delays in urgent surgical management following post-operative clavicle pain. The concern described repeated attempts to contact the consultant's secretary from October to December 2025, no call-back or appointment being arranged through that route, and later identification at Trauma Clinic that the plate had moved and was no longer secure. The concern also described delay in pre-operative paperwork being sent, lack of a clear surgery plan, unmanaged pain, A&E/GP attendances, inability to work, and distress caused by poor

communication

**What was learned and how was this shared?**

The learning from this concern highlighted the importance of reliable administrative systems to support timely follow-up booking, clear oversight of voicemail and call-back arrangements, and improved visibility of pre-operative documentation as patients move through the surgical pathway. It also reinforced the need for patients to receive timely communication when delays occur and for higher priority cases, such as RCS2 patients, to remain visible through waiting list management and validation processes. Learning has been shared with the Trauma and Orthopaedics service, Medical Records, secretarial staff and relevant pathway teams to reinforce expectations around communication, follow-up booking and escalation where delays or gaps are identified.

**What action has been taken or planned? What was the impact of this?**

Actions include reinforcing call-handling expectations within the Trauma and Orthopaedics secretarial service, including regular voicemail monitoring, timely completion of agreed call-backs and line management oversight where standards are not met. Medical Records colleagues have been reminded of the importance of booking follow-up appointments against intended clinical timeframes. The pre-operative referral process is being reviewed to provide greater clarity and consistency around the timing of Health Screening Questionnaire submission to the Pre-operative Assessment Team, and a pilot has commenced to trial earlier submission of HSQs for patients with longer waits. RCS2 priority cases will continue to be monitored through existing waiting list and validation processes. These actions are intended to improve reliability of communication, reduce the risk of missed or delayed follow-up, strengthen pathway visibility, and provide greater assurance that patients are escalated and progressed appropriately.

## HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Theatre efficiency work has agreed common metrics and is moving towards data-led improvement, supporting more consistent operational assurance.

## Outstanding Care

**Summary of feedback**

A patient wrote directly to the Chief Executive to express her appreciation for the care provided by the Short Stay Surgical Department and Short Stay Surgical Unit. The feedback highlighted the professionalism, compassion and commitment shown by both teams, particularly while working under significant service pressure.

- described the care received as “truly outstanding”;
- recognised staff who went “above and beyond”;
- praised the exceptional professionalism, compassion and commitment demonstrated by the teams;
- acknowledged that high standards were maintained despite significant pressure; and
- stated that the service “reflects the very best of the NHS”.
- **Recognition and learning**

  The patient specifically asked that the whole SSSU team receive recognition for the care provided. This feedback will be shared with the relevant teams as an example of excellent patient-centred care and as positive reinforcement of the standards expected across surgical services.

## OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

| Case No | Action | Due Date | Reason for Non Delivery | Risk (RAG) |
|---|---|---|---|---|
| ID 82094<br><br>ID 91732 | Development of a Health Board standard operating procedure for referrals and follow-up, including defined documentation | | Transition to digital clinic outcome recording, removing paper clinic outcome forms and improving | |

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|---|---|---|---|---|
| ID 82952 | standards, tracking arrangements, escalation timeframes, and role clarity. | | auditability of follow-up decisions remain in progress as part of the Health Board's Lost to Follow Up programme as part of the Clinical Excellence Programme to reduce the risk of harm associated with patients being lost to follow-up. Owned by Cath Wood | |

## NEW / CLOSED / AMENDED RISKS

New / amended risks for review:

| | | |
|---|---|---|
| **Ageing estates impacting patient care** | Clinical areas may not receive urgent estates work quickly enough, affecting safety/functionality and care quality. | 1) Agree and publish a prioritised programme of urgent works for high-risk areas 2) Continue joint estates/IPC/clinical inspections and update risk registers 3) Progress capital bids/rolling refurbishment programme (e.g., theatres) 4) Put contingency plans in place to minimise disruption to services. |
| **No resident doctor cover for spinal service (OOH)** | Spinal patients may face delayed assessment/treatment out of hours; unsafe and unsustainable reliance on trauma registrar and consultants. | 1) Develop a business case for a resident SHO rota 2) Review and redesign OOH cover model to ensure protected spinal cover 3) Implement clear response-time standards and escalation pathways 4) Improve data collection/reporting on delays and outcomes. |
| **No spinal navigation technology** | Lack of image-guided navigation increases risk of instrumentation error and serious harm; limits service capability and creates reputational/financial exposure. | 1) Finalise and progress capital business case 2) Seek capital approval to procure navigation 3) Plan implementation to embed navigation into routine practice once approved. |
| **Harm to patients on long waiting lists** | Patients waiting extended periods may deteriorate without timely review; risk of harm, emergency presentations and regulatory scrutiny. | 1) Implement a standardised harm review at defined waiting-time thresholds 2) Strengthen risk stratification/prioritisation models 3) Increase frequency of waiting list validation and review 4) Escalate capacity gaps through recovery/productivity planning with clear specialty accountability. |
| **Incomplete Discharge Advice Letters (DAL) on ePMA** | Discharge information not reliably sent to WCP/GPs; continuity and medication safety risks; potential complaints/scrutiny. | 1) Require services to clear backlogs identified in reports 2) Mandate routine use of ePMA dashboards at ward/specialty level 3) Introduce regular governance reporting and escalation for overdue DALs 4) Clarify roles/responsibilities and provide targeted education/support for prescribers. |

| CLINICAL BOARD QUALITY UPDATE REPORT | | | |
|---|---|---|---|
| **Governance Group:** | C&W CB QS&PE meeting | **Date of Meeting:** | 23/06/2026 |
| **Representative at Clinical Board Governance:** | CB, O&G, ACH, CYPFHS | **Date of Meeting:** | |

| ITEMS FOR ALERT | | |
|---|---|---|
| **Issue / Risk** | **Actions Taken** | **Support Requested** |
| Access to Age Appropriate Mental Health Beds for 16-18yr olds (RR 20) | 1. Current UHB protocol identifies the age-appropriate bed for 16–18-year-olds requiring acute mental health admission for a comprehensive psychosocial assessment to be provided by AMH'S at Hafan y Coed.<br>2. Assessment and management by EWMH Team's including Crisis team and IHTT. Out of hours on call medical team.<br>3. Functioning Crisis Team to offer support to young person, family and staff on Cedar Ward 7 days a week including bank holidays between the hours of 9am – 9:30pm<br>4. Medical on call rota available out of hours 7 days a week<br>5. Escalation process for admission and sourcing of appropriate bed in place but it is not functioning effectively | |
| Insufficient capacity in ICCNS to deliver statutory care packages (RR 20) | Approval and external advertisement of Band 3 and Band 5 posts.<br><br>Agreement to recruit to Band 4 AP and for them to administer child specific medications within agreed framework. | Approval of the band 4 medication administration policy |
| transfer of budget for CHC -LD | £39M transferred over and increased our control over spend by £5.3M. Line of sight to 1.5M saving if POC reviewed. | C&W LD team are reviewing the top 40 cases. Need workforce to undertake the reviews and reduced packages |
| Richmond support services (domiciliary support) arm of Richmond Nursing Agency disbanded.<br><br>On afternoon of Tuesday 26th May, informed that the whole of Richmond agency had gone into liquidation with immediate effect. | Currently 2 Adult LD packages of care supported by Richmond. 1 was under the Richmond support services (domiciliary support) arm for non term-time domiciliary support when person is on leave from collage. Care for immediate period was to be undertaken via continuing Richmond Nursing Agency and its governance and assurance frameworks, however 12 hours into the arrangement alternative action was needed. Staff from Richmond were moved into a new agency called Beelong, which we believe is unregistered at present and uncertain governance framework, however following discussion with Executive Director of Nursing | Continued support of use of Beelong Agency for the immediate period.<br><br>Carys Fox supporting investigation of alternative approved governance agency options.<br><br>CSIW have been informed of the interim arrangement. |

| | | |
|---|---|---|
| | and Corporate Governance it was felt this was the only option for the immediate period.<br>Work ongoing to identify alternative framework and approved providers of care. | |
| Adult Learning Disability (CHC) Governance Arrangements | Concerns regarding off-framework placements. Inability to obtain assurance around safety, quality and value of care provided due to main service responsibility sitting with Swansea Bay UHB | |
| RIF Funding Uncertainty | Concerns regarding impact of major service sustainability risk if funding ceases, with potential loss of services such as Goleudy & ENFYS. Staff uncertainty also leading to workforce retention concerns. | |

| **ITEMS TO ADVISE** | | |
|---|---|---|
| **Issue / Risk** | **Actions Taken** | **Support Requested** |
| Awaiting outcome of current BR+ assessment. Anticipated that the service is likely to be non-compliant with requirements | Assessment is ongoing. Consideration of risk to be undertaken when received. | |
| Ongoing HV JD review | Move via UNITE to move HV's in C&V to a collective Grievance stage | |
| Restarting children's rights forum | Dates being arranged and stakeholders identified | Comms support |
| Plan for ND delivery plan has gone to UHB Finance Group for ratification | Awaiting outcome from UHB Finance group | agreement |
| Requests from outside care providers for specific training in relation to long term care of tracheostomies and other related devices. | Production of a governance document which will be shared with the Corporate Governance Team and ECOD for advice. | |

| **ITEMS FOR ASSURANCE** | | |
|---|---|---|
| **Issue / Risk** | **Actions Taken** | **Support Requested** |
| Awaiting publication of recent HIW unannounced inspection of B2 Gynaecology | Report received with no significant areas of concern. Incidental findings have been responded to. Able to demonstrate compliance against all recommendations. | Comms support |
| Datix Management | Targeted approach being undertaken across all Directorates to ensure that all incidents are being reviewed in a timely manner and that none are over a year old. | |
| Reduction in C.Difficile Cases | Significant reduction in C. difficile infections compared to the previous year.<br>Only two cases reported since April. | |

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|---|---|---|
| | Improvement work recognised within the Clinical Board.<br>Work submitted for NHS Wales Awards. | |
| ePMA Rollout | Successful rollout across Children's Hospital. Positive feedback received from the implementation team. | |

| RECENT LEARNING OPPORTUNITY | | | |
|---|---|---|---|
| **Source:** | NRI Investigation | **Reference (if applicable):** | IN108215 |

**What happened / what was the problem?**

Inability to draw up oral midazolam into an ENFit syringe due to absence of appropriate needles, leading to wrong route administration.

**What was learned and how was this shared?**

ENFit syringes are available and ensures that medication required to be given orally can be drawn up into a purple syringe, which then doesn't fit to cannulas and is also a visual alert.

Shared through safety briefings and quality & safety forums

**What action has been taken or planned? What was the impact of this?**

Working with Assistant Director of Patient Safety on UHB wide improvements and relaunch of ENFit equipment.

## HIGHLIGHTS OF GOOD PRACTICE TO SHARE

**Roster Co-ordinator Model – Maternity Services**

- Reduced reliance on bank staffing.
- Significant operational efficiencies.
- Release of Band 7 time for quality, safety and service improvement work.
- Positive early workforce outcomes.
- Potential model for wider adoption across Children & Women's services.

## OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

| Case No | Action | Due Date | Reason for Non Delivery | Risk (RAG) |
|---|---|---|---|---|
| | X5 Overdue NRI's: | | | |
| IN29271 (AJH) | PSLR initiated following grading of Perinatal Mortality Review.<br><br>Awaiting final approval. Anticipated submission to Patient Safety Team for closure by mid July 2026. | Jan 2026 | Originally reported as MBBRACE. Care concerns noted following PMR, PSLR initiated April 2026.<br><br>Closure meeting set for 04/06/2026. Further amendments required. | |
| IN102543 (PT) | Final Draft shared with Patient Safety team 03/07/2026. Being reviewed. | April 2026 | PSLR progressing. IO had recent period of sickness. | |

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| | Requires final review and factual accuracy check. Closure meeting being arranged for end of July 2026. | | | |
| IN101360 (RR) | PSLR with Patient Safety Team for closure | May 2026 | Further review required following additional concerns raised at patient debrief session that required consideration as part of the review – now complete. PSLR awaiting closure | |
| IN103121 (DD) | PSLR requires further review following comments received from Patient Safety Team | June 2026 | IO currently on sick leave. Comments being reviewed for necessary action in IO absence. | |
| IN103706 (JT) | Draft PSLR received for review/comment. Also requires factual accuracy check following completion of comments | June 2026 | Requirement of external reviewer. Due to commitments in substantive role the completion of the report has been delayed.<br><br>Closure meeting set for 22/07/2026 | |

| NEW / CLOSED / AMENDED RISKS |
|---|
| All overdue HIW actions have been reviewed and actioned on AMAT |

| CLINICAL BOARD QUALITY UPDATE REPORT | | | |
|---|---|---|---|
| **Governance Group:** | Quality Committee | **Date of Meeting:** | 28.07.2026 |
| **Representative at Clinical Board Governance:** | PCIC Clinical Board Quality, Safety & Experience Group | **Date of Meeting:** | |

| ITEMS FOR ALERT | | |
|---|---|---|
| Issue / Risk | Actions Taken | Group Responsible |
| Risk in sustainability of the GP provision through the service level agreement in HMP Cardiff associated with GP concerns over accountability after themes from national reportable incidents associated with Mental Health provision. | Clinical board to Clinical Board escalation and collaboration to undertake a cross clinical board review and transformation programme following an action focused approach.<br>NRI investigations<br>Collaboration with HMP.<br>Q & S review of concerns and oversight with Exec Director of Nursing. | PCIC & Mental Health Clinical Board |
| District Nursing Escalation - level **4** due to unavailability of staff<br>• Ongoing vacancies, increasing from 18.75 WTE RN to 22.0 WTE and sickness<br>• Plan for 8.0 WTE from student streamlining | Daily prioritisation of calls, transfer of staff across teams/boundaries to mitigate risks.<br>SBAR to EDON and Director of Strategic Nursing to increase numbers of student streamliners in phase 2. | PCIC CB & UHB/Corporate Nursing for Nurse Recruitment Strategy |
| Ongoing RN vacancies within the Immunisation Team are reducing capacity to plan and implement the 2026/27 Winter Respiratory Vaccination Programme. This is further exacerbated by the changes to human medicines regulations meaning a that HCSW can no longer gain consent for vaccination, and the consequence is a need to revert to a predominantly Registered Nursing workforce model. Failure to secure the required workforce may compromise programme delivery and create a reputational risk for the Health Board, particularly regarding winter resilience and de-escalation expectations. | Recruitment approval has been sought for a minimum of 6.8 WTE through internal recruitment with a further 4.0 WTE in phase 2 Student Streamlining | Health Protection and Immunisation Business Unit and PCIC CB with Corporate Nursing for Nurse Recruitment Strategy |
| Ongoing issues have been identified relating to outstanding Discharge Advice Letters (DALs) that have not been completed, signed off and sent to patients' GPs following discharge from hospital. This creates risks to continuity of care, including delays or omissions in communicating clinical information, medication changes, follow-up requirements and investigation outcomes, with potential for patient | PCIC are part of the UHB DAL group led by AMD Patient Safety | DAL Group |

| | | |
|---|---|---|
| harm. | | |

| ITEMS TO ADVISE | | |
|---|---|---|
| **Issue / Risk** | **Actions Taken** | **Group Responsible** |
| Movement of District Nursing calls to manage daily risks impacts on timely and preventative care in the Community with potential for associated health impacts which is against the direction of the CSP | Daily prioritisation of calls, transfer of staff across teams/boundaries to mitigate risks.<br>SBAR to EDON and Director of Nursing Strategic Nursing | PCIC Clinical Board |
| Heads at HMP Cardiff, have reviewed PPO (Prisons and Probation Ombudsman) report from a death on release from HMP Cardiff which highlights concern in relation to pre-release healthcare provision, which guidance clearly outlines that all individuals should receive a healthcare review prior to release, enabling appropriate support, harm reduction, and signposting. Current practice in HMP Cardiff prioritises those with complex health or social care needs. This highlights risks associated with non-adherence to national guidance. This and other recommendations from PPO and HMP Health Needs Assessment will require workforce additionality. | Workforce review in HMP and review of opportunities for workforce reshaping<br>Cross Clinical Board working and collaboration around Mental Health Provision<br>Establishment/Funding review | PCIC Clinical Board |
| Changes to the Human Medicines Regulations now mean that Healthcare Support Workers can no longer administer vaccinations (except COVID-19) or undertake consent, significantly reducing workforce capacity and flexibility in current immunisation team workforce model with need to revert to a predominantly Registered Nursing workforce model. | Workforce review and review of opportunities for workforce reshaping and support for recruitment to Band 5 Registered Nursing posts | PCIC Clinical Board |
| HMP National Reportable Incidents and near miss incidents reported as alert last month with clear themes predominantly around Mental Health Provision are being investigated as part of standard Patient Safety Learning review process. | Clinical board to Clinical Board escalation and collaboration to review processes.<br>Rapid Review process and NRI investigations<br>Collaboration with HMP | PCIC & Mental Health Clinical Board |
| Ongoing absence of automated results management in the Department of Sexual Health following the liquidation of Millcare EPR in 2025. Agreement secured to integrate LIMS2 with Lillie Healthcare as a long-term solution, but UHB are reliant on DHCW to prioritise and deliver a replacement system interface. | Local mitigation<br>Work with UHB digital and DHCW is ongoing to get a timeline for action. | CAV Digital & Health Intelligence & PCIC CB |

| ITEMS FOR ASSURANCE | | |
|---|---|---|
| **Issue / Risk** | **Actions Taken** | **Group Responsible** |
| **Rapid Assessments tools completed for** | | |

| | | |
|---|---|---|
| **Audit plans;**<br>Integrated Discharge Service – Audit of UHB Discharge Procedure<br><br>Follow up Mental Capacity Act audit within PCIC as part of MCA audit action plan | Work with AMAT team and digital team to automate data entry<br><br>Work with Consultant Nurse for Older Vulnerable adults | Primary Care Quality & Safety |
| Ongoing use of CIVICA scheduling and PARIS (Digital patient record) to work up capacity and demand in District Nursing | Scheduling and demand Dashboard development and daily use of CIVICA to prioritise the circa 1100 calls a day undertaken by DN's | Integrated Community Care Business Unit & PCIC |
| Primary & Community Wound care review is ongoing to look at demand and the quality of wound care resulting from Local Supplementary Service hand backs from GP practices | Ongoing review | PCIC Wound Steering group |
| Men B vaccination programme – The UHB immunisation team are stepping up a significant immunisation programme starting in July 2026 after WG announced a vaccination programme for eligible 17 – 25 year olds, which is in response to UK Men B outbreaks. This will be challenging with current workforce vacancies and is likely to impact on the capacity and timeliness of the seasonal vaccination programme | Cross service review to flex workforce to meet demand and support for recruitment to Band 5 Registered Nursing posts | Health Protection and Immunisation Business Unit and PCIC CB with PHW support |

| **RECENT LEARNING OPPORTUNITY** | | | |
|---|---|---|---|
| **Source:** | Rapid Review | **Reference (if applicable):** | |
| | | | |
| Themes identified from rapid review of serious incidents in HMP. | | | |
| | | | |
| Sharing of communication of themes and immediate and collective action required by the whole healthcare team in HMP. | | | |
| | | | |
| Cross Clinical Board diagnostic work to look at governance arrangements and plan support for cross speciality clinical teams. | | | |

**HIGHLIGHTS OF GOOD PRACTICE TO SHARE**

Patient stories used in PCIC forums

Use of AAA reporting template within Business Units to escalate to Clinical Board by exception

Weekly pressure damage scrutiny panels in place with focused work with Local Authorities to hold scrutiny panels to review incidents of Pressure damage in Care homes

Proactive monitoring of Section 5 and Safeguarding referrals

| OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS | | | | |
|---|---|---|---|---|
| **Case No** | **Action** | **Due Date** | **Reason for Non Delivery** | **Risk (RAG)** |
| | | | | |
| | | | | |

| NEW / CLOSED / AMENDED RISKS |
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| CLINICAL BOARD QUALITY UPDATE REPORT | | | |
|---|---|---|---|
| **Governance Group:** | CD&T QSE Sub-Committee | **Date of Meeting:** | 24th June 2026 |
| **Representative at Clinical Board Governance:** | Director of Nursing/Multi-Professional Teams | **Date of Meeting:** | |

| ITEMS FOR ALERT | | |
|---|---|---|
| **Issue / Risk** | **Actions Taken** | **Group Responsible** |
| The new RISP system in Radiology is now live. However, there are a number of critical technical issues that need to be resolved prior to the department agreeing to the signing off of stable operations. | There are 3 critical risks identified and a risk assessment in place. Safety notice shared in relation to image quality | RISP Local Implementation Group |

| ITEMS TO ADVISE | | |
|---|---|---|
| **Issue / Risk** | **Actions Taken** | **Group Responsible** |
| HTA regulatory update requires declaration from the designated individual to review incident records from 1st April 2015 to 30th June 2026 and confirm whether all HTARI's have been reported to the HTA, any previously unreported incidents must be subsequently reported through the portal. Review to be completed by 18th September | Review commenced for Datix 2022-2026.<br>Request to access data held on previous Datix system to cover review period 2015-2022. | HTA compliance group. QSE sub-committee |
| CAV working closely with Pharmaxo and NWSSP, received a Moondance Cancer Award for collaborative working in developing the first patient self-administration pathway for Daratumumab in multiple myeloma. | It was agreed that this project will be presented to a forthcoming QSE Sub-Committee meeting. | QSE Sub-Committee |
| Ockenden Report the recommendations in relation to post death care are being reviewed by Paediatric pathology team | Report shared with HTA group, our foetal pathology unit is set up very differently to that of NUH, but thorough review of recommendations will be undertaken | HTA compliance group |

| ITEMS FOR ASSURANCE | | |
|---|---|---|
| **Issue / Risk** | **Actions Taken** | **Group Responsible** |
| The Clinical Board is subject to an internal audit relating to its governance arrangements. | Minutes and terms of reference from the key Clinical Board Meeting Groups have been submitted to the Internal Audit Team. TOR due an update on hold pending recommendations from audit | Formal Board |
| HTARI reported by mortuary service in relation to fridge failure during the heatwave, upper limit exceeded for 3-4 hours. | Mortuary manager and estates attended site in response to temperature monitoring alarm and corrective action taken.<br>No adverse effect reported on the deceased in our care, as a result of fridge failure | HTA compliance group, CD&T QSE sub committee |

## RECENT LEARNING OPPORTUNITY

| Source: | Phlebotomy incident involving a wrong blood in tube incident | Reference (if applicable): | Incident Number 106943 |
|---|---|---|---|

**What happened / what was the problem?**

The incident occurred on A6 ward and involved two patients on the ward with the same name where both patients required blood tests on the same day. Blood samples were taken from one of the patients using both patients' request forms.

The error was identified when the family of the other patient queried why clinicians already had blood results despite the patient not having had blood taken. The patient confirmed he had been off the ward at the time of the phlebotomy round.

**What was learned and how was this shared?**

The investigation found that the phlebotomist had used the ward bed board to allocate bed numbers to request forms and failed to recognise that there were two patients with the same name on the ward.
Both forms were incorrectly labelled as the same bed, leading to the phlebotomist attending the wrong patient.

The investigation highlighted that the practice of bed numbering, although not part of formal training, has been a contributory factor in several recent WBIT incidents. It was also noted that similar or identical patient names continue to present a significant risk if full identification checks are not completed.

A department-wide reminder was issued reinforcing that bed numbers must not be used as a form of patient identification and emphasising the importance of strict adherence to positive patient identification procedures, particularly where patients have the same or similar names.

**What action has been taken or planned? What was the impact of this?**

Patient identification errors can affect every area. On some wards flags are used on patient boards as a warning that there is another patient on the ward with the same name. Checks will be undertaken to try to identify which wards have this in place.

## HIGHLIGHTS OF GOOD PRACTICE TO SHARE

An event hosted by Speech and Language therapy showcases the journey around the integration of both the Babies, Children and Young People SLT Service and Adult SLT Service as a good example of collaborative working. The event also provided the opportunity for networking and learning across services.

## OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

| Case No | Action | Due Date | Reason for Non Delivery | Risk (RAG) |
|---|---|---|---|---|
| | | | | |

## NEW / CLOSED / AMENDED RISKS

A number of risks within Occupational Theapy have been actioned/closed on the AMAT system:

Occupational Therapy/2011-1201 - Occupational Therapy Spine Pathway
Occupational Therapy/2024-2502 Insufficient Occupational Therapy capacity for Acute Neurosurgery/Neurology Service
Occupational Therapy/2011-1201 Staffing shortages in the OT Stroke Pathway

No new CD&T risks have been authorised on AMAT since the last report 24 June 2026.

| CLINICAL BOARD QUALITY UPDATE REPORT | | | |
|---|---|---|---|
| **Governance Group:** | Quality Committee | **Date of Meeting:** | July 28th |
| **Representative at Clinical Board Governance:** | Cath Twamley | **Date of Meeting:** | |

| ITEMS FOR ALERT | | |
|---|---|---|
| **Issue / Risk** | **Actions Taken** | **Group Responsible** |
| Outbreak of Resistant Acinetobacter baumannii on T4 Neuro. Position 15/07/26:<br>ID 118203<br><br>• Confirmed – patient colonised/infected with Carbapenem resistant *A.baumanii* carrying NDM and OXA-23 genes **with specific genetics** (*full genetic information is still to follow from Colindale*) and with an epidemiological link to T4 since 20/6/26 (admission date of index case)<br>• Probable – patient colonised/infected with Carbapenem resistant *A.baumanni* carrying NDM and OXA-23 genes with an epidemiological link to T4 since 20/6/26 (admission date of index case)<br>• Possible – patient colonised/infected with Carbapenem resistant *A.baumanii* with an epidemiological link to T4 since 20/6/26 (admission date of index case)" | Outbreak meetings in place. Last meeting 15/07/26, next meeting 22/07/26<br><br>Strict ongoing screening regimen<br><br>Robust cross MDT action plan drafted and mobilised<br><br>All stakeholders informed and supporting improvement. Early Warning Notification sent.<br><br>Specific focus on hand hygiene and bare below the elbow, environmental factors and challenges and equipment to include beds and mattresses | T4 team, wider senior nursing team and stakeholders<br><br>IPCG and CB IP&C groups |

| ITEMS TO ADVISE | | |
|---|---|---|
| **Issue / Risk** | **Actions Taken** | **Group Responsible** |
| 7 July 26<br>NWJCC Escalation of the Electronic Assistive Device Service (EATs) service placed into Level 1 (Enhanced Monitoring) of the escalation framework level l1 to support more detailed monitoring of the service and regular review and management of the waiting list<br><br>Children's Commissioner for Wales has requested to meet with the UHB and key reps to discuss | Enhanced monitoring and robust tracking of improvement against agreed action plan<br><br>• Trialling joint training clinics for lower acuity patients<br>• Recruitment of 1.0 WTE Speech and Language Therapist (now in post)<br>• Allocation of 0.4 WTE resource to undertake a service review<br>• Exploring recruitment of 1.0 WTE Band 5 to support waiting list reduction | Specialist Services Clinical Board (SSCB) |

| | | |
|---|---|---|
| | • Urgent validation of waiting list and service spec.<br>• Urgent demand/ capacity review | |
| 22 June 26<br>NWJCC Escalation of CAVUHB Cardiac Surgery to Level 2 | Improvement action plan completed and mobilised to to ensure the delivery of a time-bound improvement action plan addressing the following:<br><br>• Establishment of robust audit systems, improved data quality, and timely national clinical audit and data submissions<br>• Assurance on clinical outcomes, including reconciliation of missing NACSA data<br>• Stabilisation of the cardiac surgery waiting list and reduction in cancellations | SSCB<br><br>Directorate team |
| De-escalation of cardiology from GMC oversight process following HEIW recommendation.<br>(NB April 7th but not previously included in report) | Concerns satisfactorily resolved | SSCB |
| Notification received via Comms Team that a four-part production is shortly due to start on a drama series, focusing on the infected blood scandal. As currently written, UHW is the location where Professor Arthur Bloom, a major character in the drama is located, working in Haematology. | Clinical Board have requested via Comms to meet with the Production company with key attendees from the Haemophilia team to gain a better understanding to manage any potential impact to patients and staff accordingly. | SSCB<br><br>Haematology/ Haemophilia Team |

| **ITEMS FOR ASSURANCE** | | |
|---|---|---|
| **Issue / Risk** | **Actions Taken** | **Group Responsible** |
| ID 116358 implantation of an expired pacing device 16/06/26 (noted under 'items to advise' in last month's report)<br><br>(NB This was retrospectively reported and occurred prior to recent actions initiated and a process review following a 'near miss' of same nature ID 112097) | Presented at UHB Quality Meeting 24/06/2026<br><br>Following review of ID 112097 it became apparent that previous actions that should now be embedded had not been fully mobilised.<br><br>This has been addressed as part of a robust action plan, to include measures | Physiology Service<br><br>Cardiac Services DMT<br><br>SSCB |

| | | |
|---|---|---|
| | to fully embed a robust management of stock SOP. | |
| Theme of recurrent heparin related incidents with varying harm across multiple UHB services. In Specialist Services these have included x2 NRIs and a Prevention of Future Deaths Notice. | Short Life Working Party set up in Specialist Services CB chaired by DON. TORs agreed but key purpose to standardise governance around prescribing of heparin infusions in response to the key theme of these incidents. | SLWP quorum as per agreed TORs, reporting into MSE with a view to wider learning and engagement across the UHB |
| Changes to Deprivation of Liberty Safeguards (DoLS) resulting from the Supreme Court judgment on the 2nd June | Updates widely shared and discussed at CB QSE Committee to be taken back to local meetings. Training uptake encouraged. | SSCB, Q&S leads and all directorate teams |
| Incomplete discharge letters on ePMA (UHB issue with regular reports shared to indicate data from across all areas) | Data widely shared within SSCB with ask for action Completion rate of DALs to be included as a quality measure moving forward at directorate performance reviews DALs writing pathway devised in Haematology. To be rolled out across the SSCB and also presented at MSE. | SSCB, Q&S leads and all directorate teams |
| Changes to Datix Cymru Restrictive Practice Reporting from July 1st 2026 | Updates widely shared and discussed at CB QSE Committee to be taken back to local meetings. Virtual training session uptake encouraged. | SSCB, Q&S leads and all directorate teams |

| **RECENT LEARNING OPPORTUNITY** | | | |
|---|---|---|---|
| **Source:** | NRIs & a related inquest | **Reference (if applicable):** | ID99048<br>ID72441<br>ID108606 |
| **What happened / what was the problem?** | | | |
| One of the contributary factors identified as a theme was nursing gaps as a consequence of not being able to appropriately staff Critical Care to the agreed signed off numbers, not possible to effectively mitigate given required skills and numbers | | | |
| **What was learned and how was this shared?** | | | |
| Theme noted through NRIs and Critical Care meetings to include M&M, Q&S, DMT and Consultant meetings | | | |

| What action has been taken or planned? What was the impact of this? |
|---|
| Escalation through appropriate channels to include discussion with Exec. Nurses<br>Approval to recruit to 98% establishment (despite wider UHB model of 95%)<br>Deep dive of staff unavailability and actions to address those factors that can be influenced effectively eg. sickness |

## HIGHLIGHTS OF GOOD PRACTICE TO SHARE

▪Specialist Services Staff Recognition Awards 30th June

▪Haematology Duy Unit Staff Nurse, Emma Gordon won a GREATix award for creating a concise printed summary of each patient's reason for attendance and relevant details for that day, specifically to support and streamline handover

▪Critical Care Nurse, Amelia Barnsley was named June's Health Hero in recognition of the outstanding care and compassion she provided to a patient and their family. She said, "I am so prout to be an intensive care nurse. I think it's the best job in the world"

▪Cardiff and Vale UHB, working closely with Pharmaxo and NHS Wales Shared Services Partnership, has received a Moondance Cancer Award for our collaborative work in developing the first patient self-administration pathway for Daratumumab (Darzalex®) in multiple myeloma.

▪Letter received by Suzanne Rankin from the CEO of Hemab Therapeutics (a clinical stage biotech company developing prophylactic antibody therapies to treat rare, underserved blood coagulation disorders). The letter praises the Haematology Research Nurse team for their hard work and commitment to supporting the Hemab Tx study and that they are going to be considered as a globally preferred site for the sponsor going forward. This is a huge achievement and recognises the quality of the research service delivered, strengthening Cardiff and Vale's reputation as leading centre for research.

## OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

| Case No | Action | Due Date | Reason for Non Delivery | Risk (RAG) |
|---|---|---|---|---|
| | | | | |
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## NEW / CLOSED / AMENDED RISKS

Specialist Services Clinical Board led meeting with all directorates scheduled for 24/07/26 to review and undertake a risk moderation exercise of all risks scoring 20 and above.

| CLINICAL BOARD QUALITY UPDATE REPORT | | | |
|---|---|---|---|
| **Governance Group:** | Discussed in MHCB Formal Meeting | **Date of Meeting:** | 9th July 2026 |
| **Representative at Clinical Board Governance:** | Mental Health Clinical Board | **Date of Meeting:** | Next QSE meeting 7th August 2026 |

| ITEMS FOR ALERT | | |
|---|---|---|
| **Issue / Risk** | **Actions Taken** | **Group Responsible** |
| • Datix backlog remains high, with approximately 1,000 open incidents and significant non-compliance against 7- and 30-day review standards. This continues to impact timely learning, closure and assurance.<br>• Variation in the quality, consistency and grading of incident reviews has been identified, requiring strengthened oversight, standardisation and targeted support across services. | • Weekly tracking of moderate and above incidents, Datix Days and enhanced MHCB oversight are in place to support improved incident management, backlog reduction and timely learning.<br>• The MHSOP improvement plan is demonstrating early impact, with a reduction of 305 open incidents (31.6%) between 24 April and 17 June, alongside strengthened local oversight and escalation.<br>• The learning from this approach is being extended across Adult Mental Health to support consistency, sustained improvement and improved assurance against review standards. | Interim Director of Nursing Safety Pillar |
| Continued reliance on Out of Area (OOA) placements remains a significant operational, quality and financial risk. This reflects sustained bed pressures, challenges with patient flow and delayed repatriation, with potential impact on patient experience, continuity of care and local system capacity. | • Weekly OOA Board Rounds are in place to review all OOA patients, confirm clinical rationale, agree repatriation plans and identify actions to reduce avoidable delay.<br>• OOA reduction and patient flow actions are being monitored through directorate and MHCB governance arrangements, | • Clinical Board oversight is provided jointly by the Interim Director of Nursing and Interim Director of Operations, with operational delivery led through the Adult Mental Health Directorate Management Team. |

| | | |
|---|---|---|
| | with focused oversight of discharge planning, length of stay, escalation and system-wide barriers to flow.<br>• Additional Consultant Psychiatrist oversight in OOA board rounds.<br>• An OOA plan has been developed | • Governance and delivery are supported through OOA Board Rounds, OOA / Patient Flow meetings and directorate flow huddles focused on repatriation, discharge, length of stay and escalation of barriers. |
| Recent HIW feedback identified that mandatory training compliance is not yet at the required level within the Adult Mental Health Rehabilitation service, creating a potential risk to staff competence, patient safety and regulatory assurance. | The HIW improvement plan for Meadow and Daffodil is focused on rapid recovery of safety-critical training compliance across four priority areas: ILS, SIMA, Safeguarding Level 3 and VAWDASV. Progress is being monitored through weekly performance oversight, escalation and sustained MHCB assurance arrangements. | Interim Director of Nursing<br>Interim Lead Nurse, Adult Mental Health<br>Adult Mental Health Performance Meetings |

| **ITEMS TO ADVISE** | | |
|---|---|---|
| **Issue / Risk** | **Actions Taken** | **Group Responsible** |
| Increasing demand for ADHD assessment and treatment is resulting in sustained pressure on waiting lists, with associated risks to timely access, patient experience, clinical prioritisation and wider service capacity. | Demand, capacity and waiting list position are being monitored through directorate and Clinical Board governance arrangements. The service is reviewing triage, prioritisation and pathway arrangements to support risk-based access, improve communication with patients awaiting assessment, and identify opportunities to increase capacity and improve flow. | Adult Mental Health Directorate Management Team<br>MHCB Performance and Quality Governance arrangements<br>Clinical Board oversight. |
| Workforce pressures continue to affect resilience across mental health services, including vacancies, sickness | The workforce position is being monitored through | Mental Health Clinical Board |

| | | |
|---|---|---|
| absence, temporary staffing reliance and roster fill challenges. This may impact continuity of care, staff wellbeing, quality and financial sustainability if sustained. | directorate performance arrangements, with oversight of roster compliance, temporary staffing usage, sickness management, recruitment and escalation of areas of concern. Targeted support is being provided to services with the greatest staffing fragility. Additional streamliners are being requested to support any vacancies which have occurred following original submission. | Directorate Management Teams<br>Workforce and Finance leads |
| Current provision for people with Complex Emotional Needs remains variable across the pathway, particularly for individuals with mild to moderate self-harm who may not meet CMHT thresholds. This creates a risk of inconsistent access, repeated crisis presentation and limited preventative support. | Scoping is underway to develop a more consistent pathway across primary care, secondary care, crisis services and specialist psychological interventions. | Interim Director of Nursing<br>Interim Director of Psychology and Psychological Therapies<br>Adult Mental Health Directorate<br>MHCB Quality and Safety governance arrangements. |

| **ITEMS FOR ASSURANCE** | | |
|---|---|---|
| **Issue / Risk** | **Actions Taken** | **Group Responsible** |
| The MHSOP Datix improvement plan is providing assurance that focused oversight, local leadership and targeted support can reduce incident backlog and improve review compliance. Early impact is demonstrated by a reduction of 305 open incidents, representing a 31.6% decrease between 24 April and 17 June. | Weekly oversight, Datix Days, focused local review sessions and escalation arrangements are in place. Learning from the MHSOP approach is being used to inform wider improvement across Adult Mental Health, with a focus on review quality, timeliness, grading | MHSOP Directorate Management Team<br>Interim Director of Nursing<br>Safety Pillar Workstream<br>MHCB Quality and Safety governance arrangements |

| | | |
|---|---|---|
| | consistency and closure of learning actions. | |
| The HIW improvement plan for Meadow and Daffodil is subject to strengthened governance and weekly monitoring, providing assurance that required actions are being tracked, evidenced and escalated where needed. | Priority actions are being monitored through weekly oversight arrangements, with particular focus on mandatory training compliance, evidence capture, action closure and sustained assurance ahead of further review. | Interim Director of Nursing<br>Interim Lead Nurse, Adult Mental Health<br>Adult Mental Health Directorate Management Team<br>MHCB Quality and Safety governance arrangements. |
| Weekly OOA Board Rounds are providing improved visibility and control of Out of Area placements, including clinical rationale, repatriation planning, length of stay and escalation of barriers to discharge. | All OOA patients are reviewed through weekly Board Rounds, with actions monitored through OOA / Patient Flow meetings and directorate flow huddles. This provides improved grip on repatriation planning, discharge barriers and escalation requirements. | Interim Director of Nursing Interim Director of Operations<br>Adult Mental Health Directorate Management Team<br>OOA / Patient Flow governance arrangements. |
| The team are working through the Eating Disorders immediate action improvement plan, with 5 actions now rated green and 8 actions rated amber. One of the actions was to secure independent expert support for the service, and an independent eating disorder expert has now started with the team. | The independent expert is reviewing the current model before working with the team to propose a future model of care for eating disorders. The review will consider current pathways, operational arrangements, clinical governance, workforce and service sustainability. | Adult Mental Health Directorate Eating Disorders Service Leadership Team<br>Interim Director of Nursing<br>Interim Director of Operations<br>MHCB Quality and Safety governance arrangements. |

| **RECENT LEARNING OPPORTUNITY** | | | |
|---|---|---|---|
| **Source:** | HIW visit to Meadow and Daffodil Wards | **Reference (if applicable):** | HIW immediate assurance feedback; CD Integral |

| | | | |
|---|---|---|---|
| | | | Valve Oxygen Cylinder video; Safeguarding Children and Adults Group C / Level 3 training update. |

**What happened / what was the problem?**

Recent HIW feedback for Meadow and Daffodil identified gaps in safety-critical training and staff awareness, including the safe use of portable oxygen cylinders and Safeguarding Level 3 compliance. HIW noted that staff were not consistently aware of the Patient Safety Notice / Regulation 28 learning relating to portable oxygen cylinders, and that staff who may use portable oxygen cylinders require competency-based training in their safe operation. The visit also highlighted the need to recover Safeguarding Level 3 compliance across the wards and ensure the wider Mental Health Clinical Board understands the updated requirement for Group C / Level 3 safeguarding training.

**What was learned and how was this shared?**

Learning was shared immediately following the HIW feedback. Suzie Cheesman shared the CD Integral Valve Oxygen Cylinder Operation video for all relevant staff to watch; the video is 3 minutes 44 seconds long and provides practical awareness on safe operation of integral valve oxygen cylinders. The instruction was cascaded for staff to view the video as soon as possible, with completion recorded and staff asked to sign to confirm they had watched it.

Additional safeguarding learning was shared following Fiona Bullock's update on Group C / Level 3 safeguarding training requirements. This confirmed that all Agenda for Change Band 6 qualified staff and above, and F1 medics and above, are now required to complete Group C / Level 3 Safeguarding Children and Adults training every three years. An additional training date has been made available on 15 July 2026, bookable via ESR, to support recovery of compliance.

**What action has been taken or planned? What was the impact of this?**

The oxygen cylinder learning has been cascaded to ward and senior nursing teams, with staff asked to complete the video and local records retained as evidence of completion. This provides immediate mitigation while competency-based training and wider assurance arrangements are strengthened.

Safeguarding Level 3 recovery is being monitored through the HIW improvement plan and weekly oversight arrangements. Staff are being booked onto available Group C / Level 3 training sessions, attendance will be tracked, and non-attendance or exceptions will be escalated.

The impact is improved awareness of oxygen cylinder safety requirements, clearer accountability for evidencing completion, and strengthened assurance that safeguarding competence requirements are understood and being acted upon across the relevant workforce.

## HIGHLIGHTS OF GOOD PRACTICE TO SHARE

The service has completed its SIRAN mid-point review and maintained accreditation with the Royal College of Psychiatrists until January 2027. SIRAN is the Safety Incident Review Accreditation Network, a Royal College of Psychiatrists accreditation network used to support high-quality safety incident review, learning and improvement. Cardiff and Vale is currently the only Health Board in Wales to have achieved this accreditation, and

one of 11 organisations across the UK, including Cardiff and Vale. Maintaining accreditation provides positive assurance that the service continues to meet expected standards for incident review, governance, learning and continuous improvement, and demonstrates ongoing commitment to quality and safety.

## OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

| Case No | Action | Due Date | Reason for Non Delivery | Risk (RAG) |
|---|---|---|---|---|
| | Protocol for harmful substances | April 2026 | Has been out for comments and awaiting ratification at quality committee and clinical effectiveness | Amber |
| | Complex Emotional Needs Pathway | April 2026 | Further work required following lived experience workship – date extended to September.<br>Needs to align with CMHT workstream. | Amber |
| | Please note, there are 48 actions to be reviewed on AMAT – meeting set up August 2026 to review these as a CB. | | | |

## NEW / CLOSED / AMENDED RISKS

| Risk ID | Date raised | Service | Title | Initial rating | Current rating | Target rating |
|---|---|---|---|---|---|---|
| Mental health/2026-27/03 | 18/05/2026 | Division: Mental health | Lack of integration of key clinical competencies into ESR impacting real-time monitoring and compliance within the MHCB mandatory training framework | A 15 | A 15 | G 1 |
| MHSOP/2026-27/02 | 29/06/2026 | Business unit: MHSOP | Risk associated with scabies infections | A 15 | A 15 | G 4 |
| MHSOP/2026-27/01 | 01/06/2026 | Business unit: MHSOP | risk of infection and dgnity risk associated with a lack of suitable bed linen | A 9 | A 9 | G 4 |

3 new risks since April 2026

| | | | | | |
|---|---|---|---|---|---|
| Report Title: | Clinical Safety Group Update | | Agenda Item No: | | 3.2 |
| Meeting: | Quality Committee | Public | X | Meeting Date: | 28.07.2026 |
| | | Private | | | |
| Lead Executive Title: | Executive Nurse Director | | | | |
| Report Author/s Title: | Assistant Director of Quality and Patient Safety. | | | | |

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

**ALERT** *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

**ADVISE** *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

The Clinical Safety Group receives assurance from each of the clinical governance groups across the UHB on an annual basis. Clinical Board representation at these groups as well as the Clinical Safety Group remains the greatest risk to the clinical governance framework.

A review of the clinical governance groups, membership, attendance and terms of reference is underway to strengthen the engagement and governance.

**ASSURE** *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

The Clinical Safety Group has a rolling programme of presentation from the UHB Clinical Governance Groups across the UHB. April Clinical Safety Group heard only one annual assurance report from the Medicines Safety Executive. The assurance report included oversight of work around management of adrenal crisis, risk assessment and safeguards around administration of non-liposomal formulations, and presented the ongoing work to mitigate heparin related incidents. The Clinical Safety Group heard about the the use of Datix incidents in focusing work around medicines safety and plans to extrapolate information from ePMA for the same purpose.

The Surgery Clinical Board presented a incident relating to the handling and delivery of hazardous material and took away an action to escalate to Health and Safety to review the controls in place to prevent a similar incident.

- Work to mitigate two patient safety alerts was presented PSA020**:** A Health Board-wide programme is underway to address the risk of patient harm from incorrect allergy recording, particularly where penicillin allergies are mistakenly recorded as penicillamine allergies across multiple digital systems.
- PSA021**:** Work is being undertaken to standardise respiratory equipment and remove non-vented breathing circuits to reduce the risk of catastrophic patient harm associated with their use, particularly during patient transfers between clinical areas.

| **Board/Committee Response Required** ***(please select only one)*** | | | | | |
|---|---|---|---|---|---|
| **Assurance** | X | **Approval** | | **Information/Noting** | x |

**Recommendations**

The Committee is asked to:

- Note the information provided to the Clinical Safety Group and the ongoing actions as well as the development of the agenda to support improved engagement and representation.

**Governance Route *(please list all other Committee/Groups this report has been to)***

| | |
|---|---|
| ***Where** it's been:* | |
| ***When** it went:* | |
| ***What** decision was made:* | |

**Main Report**

*Background & Current Situation*

The Clinical Safety Group is a multidisciplinary forum established to support the identification, communication and management of new, emerging and existing clinical safety risks across Cardiff and Vale University Health Board. The group brings together representatives from specialist clinical safety groups, clinical boards and corporate functions to ensure that risks are identified early, appropriately escalated and visible through the organisation's governance structure. Its role is to support the development of both operational and strategic approaches to risk management, facilitate organisational learning, and drive improvement in patient safety and quality of care. The group provides an important mechanism for synthesising intelligence from multiple sources, enabling cross-cutting risks to be recognised and addressed through coordinated organisational action. Recent discussions have also emphasised the group's evolving role in strengthening system-wide oversight, supporting shared learning and ensuring that safety intelligence is translated into meaningful improvement activity across the Health Board.

The April meeting included a strategic discussion regarding the future development of the Clinical Safety Group following findings from an internal review of clinical governance arrangements. Members considered how the group could strengthen its role within the wider governance system by moving beyond the review of individual reports towards a more strategic focus on identifying recurring themes, synthesising intelligence from multiple sources and supporting organisation-wide learning. Particular emphasis was placed on the need to improve how information from incidents, audits, complaints, inspections and specialist safety groups is brought together to identify emerging risks and drive improvement. Members recognised that many safety risks cut across organisational boundaries and require coordinated responses rather than isolated action.

A significant focus of the meeting was the annual assurance presentation from the Medicines Safety Executive (MSE). The Medicines Safety Executive provides strategic oversight of medicines governance, safety and quality improvement across the Health Board. Its work is underpinned by national legislation, regulatory requirements, patient safety alerts and local medicines governance frameworks. The

group monitors medicines-related incidents, undertakes thematic analysis, responds to national safety concerns, oversees implementation of medication-related safety initiatives and provides assurance regarding compliance with national guidance and safety alerts.

The update highlighted a broad programme of improvement activity aimed at reducing medicines-related harm. This included work to address risks associated with critical medicines, improvements following national concerns regarding adrenaline administration during resuscitation events, enhanced safeguards around high-risk medicines such as amphotericin, and ongoing work relating to prescribing safety. Particular attention was given to the implementation of the Electronic Prescribing and Medicines Administration (ePMA) system. While the digital system has provided significant opportunities to improve medicines safety through enhanced prescribing controls and reporting capabilities, the group recognised that implementation of new technologies also introduces new risks which require ongoing monitoring and mitigation. The Medicines Safety Executive also reported concerns relating to delayed and omitted medicines, variation in medicines management during patient transfers and the need to strengthen clinical board engagement in medicines governance arrangements.

The April meeting also considered emerging risks requiring wider organisational awareness as presented by the Clinical Boards. These included risks associated with the incorrect delivery of hazardous materials within the Health Board, which may expose staff and patients to potentially dangerous substances if delivered to unsuitable locations. The issue was recognised as extending beyond radiation-related materials and was escalated for wider health and safety review.

In addition, the group received updates regarding national Patient Safety Alerts requiring significant organisational action. These included work to address risks arising from the incorrect recording of penicillin allergies within multiple digital systems and the management of breathing circuits lacking a patent exhalation route. Both issues required coordinated action involving numerous clinical and corporate teams to ensure consistent implementation and reduce the risk of serious patient harm.

**Appendices:**

- Minutes of the April Clinical Safety Group

**Strategic Alignment – Shaping Our Future Wellbeing:**

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

**Impact Assessment**

**Risk**: Yes

*Clinical Board representation at the clinical governance groups and overarching clinical safety group is variable and limits*

| |
|---|
| **Safety**: Yes |
| Each of the clinical governance groups has an important role in leading the strategic direction in relation to the areas they cover. This includes having a responsive approach to mitigating risk, developing and overseeing training and policy. |
| **Financial**: No |
| **Workforce**: Yes |
| *The clinical governance groups are instrumental in developing the systems, processes and developing the training which support the workforce in delivering their clinical functions* |
| **Legal**: No |
| **Reputational**: Yes |
| The UHB has a duty to ensure that it able to provide safe and effective care and the clinical governance groups are key in supporting this function |
| **Socio Economic**: No - *https://www.gov.wales/socio-economic-duty-guidance* |
| **Equality & Health**: No |
| **Decarbonisation**: No |
| **Welsh Language**: No |

| | | | | | |
|---|---|---|---|---|---|
| Report Title: | Clinical Effectiveness Committee Update | | Agenda Item No: | | 3.3 |
| Meeting: | Quality Committee | Public | X | Meeting Date: | 28.07.2026 |
| | | Private | | | |
| Lead Executive Title: | Executive Medical Director | | | | |
| Report Author/s Title: | Assistant Director of Nursing / Associate Medical Director for Patient Safety and Clinical Effectiveness | | | | |

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

**ALERT** *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

**ADVISE** *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

The UHB failed to submit data to the 2025 Patent Foramen Ovale Closure (PFOC) Registry but has subsequently put in place arrangements to ensure data input.

The UHB case ascertainment for the National Early Inflammatory Arthritis Audit was low
Meaning that the data could not be used to reliably benchmark the organisation.

The 2025 Paediatric Diabetes Audit recorded the UHB as an outlier for paediatric type 1 HbA1C. Improvement work, including work to increase the use of insulin pumps has resulted in a reduction in median HbA1c from 63 to 59 mmol/mol.

**ASSURE** *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

The Clinical Effectiveness Committee has oversight of all national clinical audits and in April and May heard presentations relating to the outcomes, improvements and risks associated with

The national Joint registry, National Diabetes Footcare Audit, National Diabetes Audit, National Paediatric Diabetes Audit, National Inflammatory Arthritis Audit and The Patent Foramen Ovale Closure (PFOC) Registry

| **Board/Committee Response Required** ***(please select only one)*** | | | | | |
|---|---|---|---|---|---|
| **Assurance** | | **Approval** | | **Information/Noting** | x |

**Recommendations**

The Committee is asked to:

- Note the information presented to the April and May Clinical Effectiveness Committee and the plans to strengthen the assurance and oversight of improvements presented to the committee.

| **Governance Route** ***(please list all other Committee/Groups this report has been to)*** | |
|---|---|
| ***Where** it's been:* | |
| ***When** it went:* | |
| ***What** decision was made:* | *e.g. Recommended to Board for approval* |

**Main Report**
*Background & Current Situation*

The annual National Clinical Audit and Outcomes Review Plan is the list of National Clinical Audits and Outcome Reviews that all health boards and trusts in Wales are expected to participate, where they provide the service. The outcomes, improvements and risks associated with national audits are presented to the Clinical Effectiveness Committee as well as uptake and implementation of NICE guidance.

Clinical Board specific committees are facilitated as far as possible to support engagement and attendance of the triumvirate, however, there remain ongoing challenges around attendance. The Associate Medical Director for Patient Safety and Clinical Effectiveness and the Assistant Director of Quality and Patient Safety will work with Clinical Boards to agree a revised approach that strengthens the Clinical Boards oversight and assurance reporting of the audits.

In April and May 2026, the Clinical Effectiveness Committee heard presentations relating to the following audits:

# Audit

## National Joint Registry (NJR) – Orthopaedic Surgery

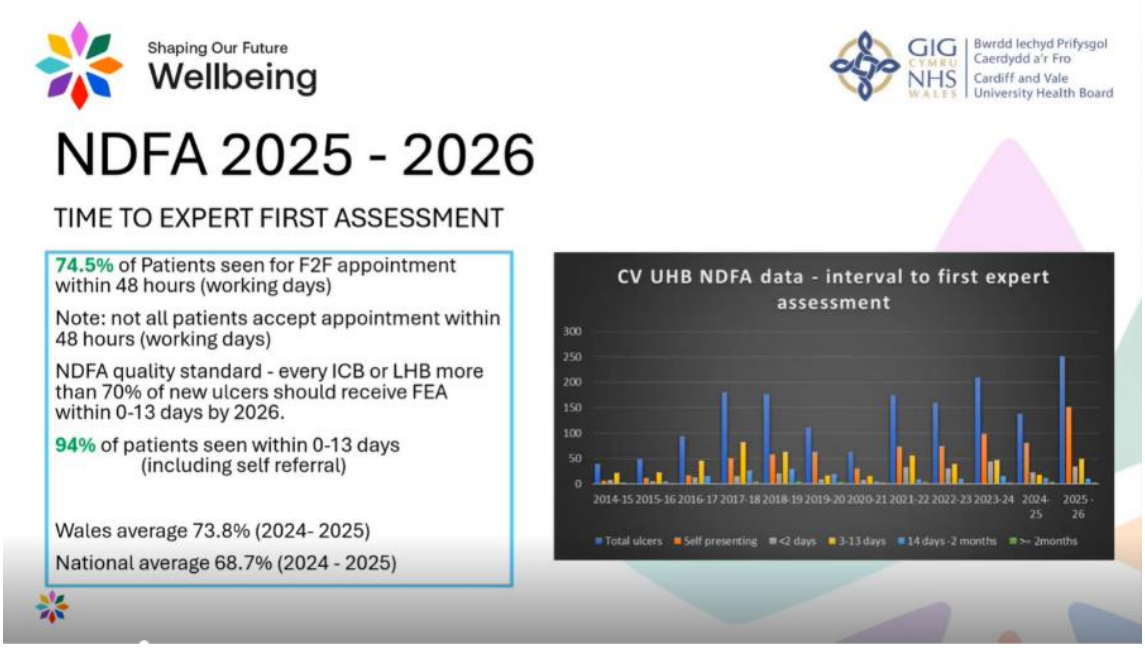
The National Joint Registry (NJR) was published in November 2025 and captures care provided between April 2024 to March 2025 and provides oversight of joint replacement activity across England, Wales, Northern Ireland, the Isle of Man and the Channel Islands. Cardiff and Vale University Health Board continues to demonstrate strong performance across key measures, with data quality remaining high with case ascertainment of 98%, however 91% of patients have been consented for their data to be stored within the registry , below the UK standard of 95%. This issue is particularly at University Hospital Wales where the large trauma workload creates challenges in obtaining consent for registry data collection.

Revision rates for both hip and knee replacements remain within expected parameters, mortality rates are aligned with national benchmarks, and no surgeons or services have been identified as outliers. Overall, the audit provides assurance regarding the quality and safety of joint replacement surgery delivered within the Health Board.

The most significant risk identified by the audit relates to higher-than-expected deep infection rates at University Hospital Llandough. The audit presentation identified several contributory factors including increasingly complex patient comorbidities, antimicrobial resistance and longstanding theatre infrastructure issues, particularly around ventilation and temperature control. These infrastructure limitations have previously led to operating list cancellations and continue to present a risk to service resilience and infection prevention. Mitigating actions are in place. Weekly multidisciplinary infection review meetings are undertaken to support early identification and management of cases. Clinical practice has also evolved in response to increased revision rates associated with uni-compartmental knee replacement, with revised patient selection criteria expected to improve future outcomes. In addition, plans for the development of the regional joint replacement centre at Centrescent Health Park are expected to address some of the environmental challenges currently faced by the service, although workforce sustainability remains an identified consideration. The overall audit position provides good assurance, with improvement activity focused on infection prevention, infrastructure and data completeness.

## National Diabetes Foot Care Audit (NDFA)

The National Diabetes Foot Care Audit demonstrates strong performance by Cardiff and Vale University Health Board across a range of process and outcome measures. The Health Board has an established multidisciplinary diabetes foot service which is well integrated with community services and delivers rapid access arrangements through the Diabetes Foot Emergency Early Triage pathway. Performance exceeds both Welsh and UK averages for timely assessment of new ulcers, with 94% of patients receiving specialist assessment within 13 days and almost three-quarters being reviewed within 48 working hours. Healing outcomes are also positive, with rates consistently exceeding Welsh and national comparators. More than half of patients were alive and ulcer-free at 12 weeks, representing continued year-on-year improvement.




Despite these positive findings, the audit highlights several service risks associated with capacity and service provision. There remains limited access to rehabilitation services and psychological support for patients with diabetes-related foot disease. The absence of a commissioned inpatient diabetes foot service creates variation in access to specialist care across clinical settings and may limit opportunities for earlier intervention in hospitalised patients. Audit ascertainment rates also remain low due to reliance on paper-based systems and incomplete data capture.

Improvement work is already underway. The service is progressing plans to improve digital data collection through collaboration with Digital Health and Care Wales and exploration of interim solutions through the Audit Management and Tracking system. Work is also focused on increasing the number of independent prescribers, embedding care pathways across the Health Board and supporting future research and review activity relating to diabetes-related amputations. These developments aim to strengthen both clinical outcomes and the completeness of future audit submissions.

## Inpatient Diabetes Audit and Patient Safety

The Health Board is not currently participating in the National Inpatient Diabetes Audit due to the absence of suitable information technology infrastructure. Whilst this limits external benchmarking opportunities, local review of patient safety information has identified important recurring themes relating to prescribing, dispensing, administration and discharge processes involving insulin and diabetes medications. These findings present an ongoing patient safety risk, particularly given the significant harm that can be associated with insulin errors.

The primary risk identified is variation in staff knowledge and competency relating to diabetes management. Reported incidents include incorrect prescribing, omitted doses, medication supply problems and patients being discharged

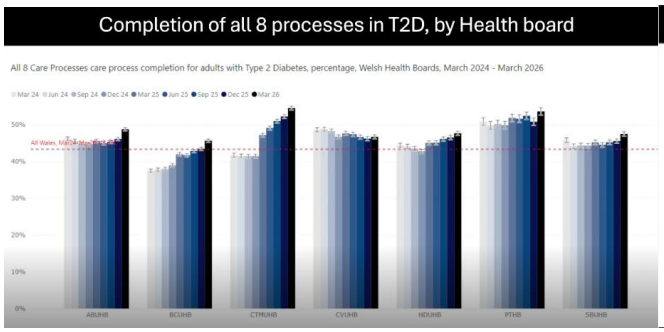
without necessary treatment or equipment. The audit discussion concluded that many of these incidents are potentially preventable through improved education, enhanced clinical oversight and stronger inpatient diabetes support arrangements.

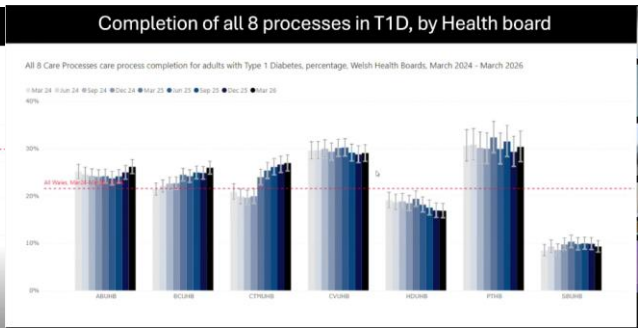
A number of improvement initiatives are being progressed. The service is working with Digital Health and Care Wales on the development of a new database to support future participation in national audit programmes. Consideration is also being given to mandatory insulin education for staff groups involved in prescribing and administration. Development of a dedicated inpatient diabetes team is underway to provide a proactive approach to patient identification, education, specialist advice and discharge support. Further work is progressing to establish electronic identification of patients with diabetes on admission and to support achievement of higher-level inpatient diabetes accreditation standards.

## National Diabetes Audit (NDA)

The National Diabetes Audit was published in February 2026 and relates to care provided between April 2024 to March 2025 . The report confirms that the prevalence of diabetes continues to increase across Cardiff and Vale, reflecting national trends and presenting a growing challenge for services. The burden is particularly evident amongst younger adults and those living in areas of deprivation.

The audit records compliance with eight care processes that include, HBA1C (a measure of blood glucose level control), urinalysis  to check for kidney function, blood lipids, blood pressure, smoking status , foot check and Body Mass Index. Completion of all eight recommended care processes for patients with Type 2 diabetes remains above the Welsh average, although performance has declined compared with previous years. Completion rates for patients with Type 1 diabetes remain significantly lower, with missing secondary care data contributing to under-reporting and emphasising the need for a unified data source.




In Wales around 43% of all people with Type 2 diabetes have all eight-care process, the UHB performance exceed the All-Wales rate however, this has been declining over the past two years, while most other health organisations in Wales are showing marked improvements. The greatest proportion of patients with type 2 diabetes are in  the 40-64 age bracket and 39% of all patients with type 2 diabetes in Cardiff and the Vale are in the areas of greatest deprivation.

Around 23% of people across Wales with type 1 diabetes have all eight care processes recorded. This rate is exceeded across Cardiff and Vale UHB but continues to fall well below the required standard. The data for the Core Diabetes audit is collected in primary care, while the majority of patients with type 1 diabetes have their care processes undertaken in secondary care.

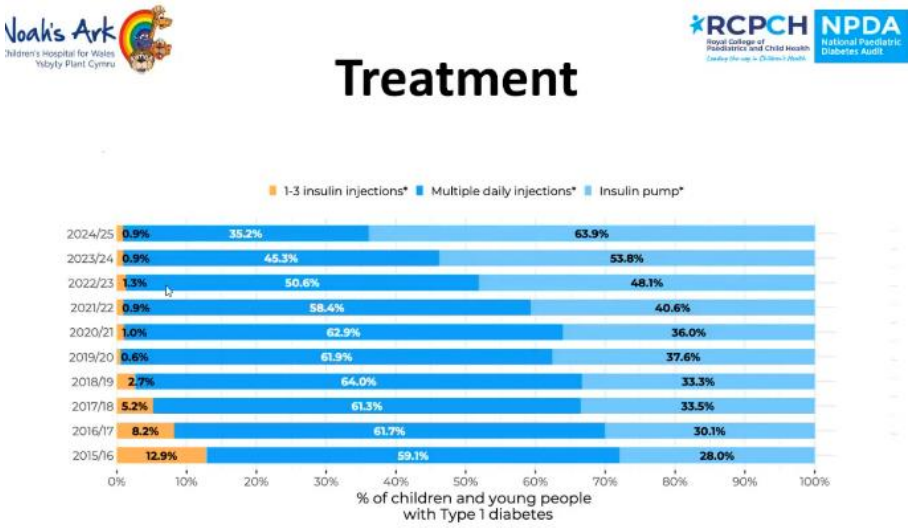
The audit highlights variation in performance between primary care clusters and practices. Lower levels of compliance are seen within more deprived communities, where prevalence is highest. Such variation presents a risk of inequality in outcomes and potentially missed opportunities for prevention of long-term complications. Foot checks and urine albumin testing continue to be the care processes most frequently omitted. The recent availability of performance data at practice level will improve local improvements.

The Diabetes Programme Delivery Group has established a number of workstreams to address these challenges. A key objective is achievement of a 10% improvement in care process compliance. Diabetes programme delivery group will operationally oversee of a number of workstreams which will include sharing best practice and support the lowest performing practices. Work is being undertaken to improve the coding of diabetes care to ensure accurate data collection.  Recent improvements in glycaemic control indicators indicate that education and support initiatives delivered through primary care are beginning to have a positive impact. A diabetes specialist nurse has been appointed to the City and South Cluster, which demonstrates the lowest compliance

## National Paediatric Diabetes Audit (NPDA)

The National Paediatric Diabetes Audit was published in March 2026 and explores the care provided between April 2023 and March 2024. Nationally HbA1C (blood glucose control) for children with type 1 diabetes has improved from 60 to 58 mmol/mol. However, Cardiff and Vale was recorded as being an outlier with a mean HbA1c of 68.7mmol/mol and median of 63mmol/mol. There is evidence that other organisations that have significantly lower HbA1c have put in place a pump pathway to support initiation of insulin pumps within 10 days of diagnosis. Between 2023 and 2024 the pump service in Cardiff and Vale was paused due to staffing constraints, but work has been undertaken to refocus resources to increase capacity and the service is now able to increase the number of children commenced on insulin pumps from five to twelve a year. The median HbA1c has subsequently reduced from 63 to 59mmol/mol.

Cardiff and Vale ranks within the top five percent of paediatric diabetes units nationally for completion of recommended healthcare checks and 100% of children were given structured education around carbohydrate counting within three months of diagnosis.



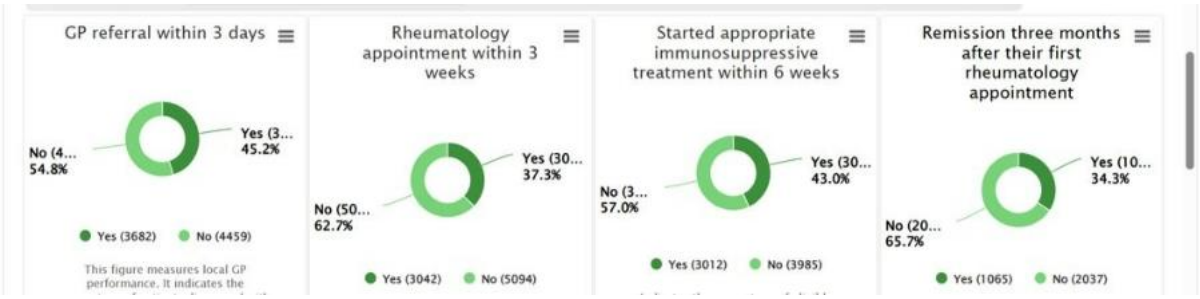

The principal risk relates to workforce capacity within the multidisciplinary team. The audit noted that Cardiff and Vale has the lowest staffed paediatric diabetes multidisciplinary team in Wales and staffing levels are below national standards. A business case is being developed for additional resource, with executive and clinical board support requested to address capacity gaps, reduce inequity and improve clinical outcomes.

## National Early Inflammatory Arthritis Audit

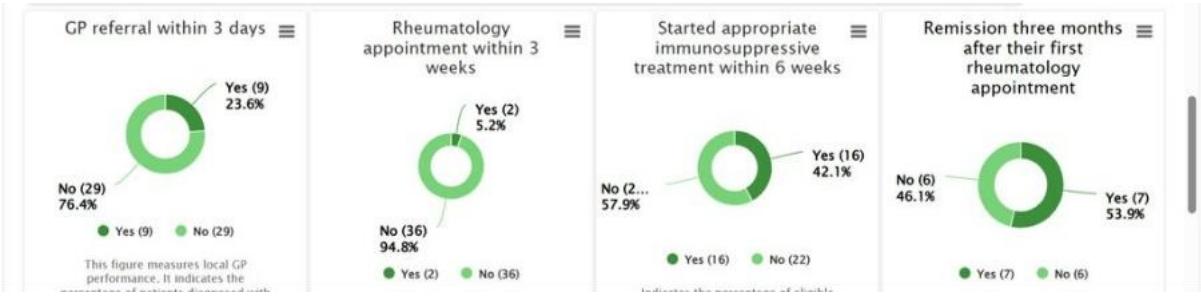
The National Early Inflammatory Arthritis Audit was published in October 2025 and relates to care provided between April 2024 and March 2025 and provides assurance that patients who access the rheumatology service are achieving favourable early treatment outcomes, with remission rates at three months exceeding national averages. However, audit

participation and performance against key access standards remain below expected levels with approximately 10% of eligible cases captured. Performance against referral and assessment timelines is significantly below both national standards and peer performance.

National Results




Cardiff UHB Results




The audit identifies a number of service risks. Delays in referral processing, workforce shortages and limited clinic capacity are affecting the ability to assess patients within nationally recommended timescales. Timely access to specialist assessment is particularly important in inflammatory arthritis, as early treatment is associated with improved clinical outcomes, reduced disability and reduced reliance on costly advanced therapies. The audit also highlights concerns regarding administrative capacity, data collection and follow-up arrangements, which may limit the reliability of reported outcomes.

The British Society of Rheumatology recommends 1 rheumatologist per 60 000 to 80 000 population with the UHB falling below this standard with 4.5 whole time equivalent consultants in post. Improvement work is underway. The service has redesigned its clinical model to increase the number of dedicated early arthritis appointments through all consultant teams, rather than a single specialist clinic. Engagement has also taken place with medical records services to address referral processing delays. Additional support for data collection has been explored and the service is investigating opportunities for digital solutions to facilitate audit data capture. Longer-term improvements will require additional clinical and administrative capacity to align service provision with recommended workforce standards.

## National Audit of Care at the End of Life (NACEL)

The National Audit of Care at the End of Life (NACEL) published a State of the Nation Report was published in August 2025 and is based on care delivered between January to December 2024 and  provides positive assurance regarding the quality of end-of-life care delivered across Cardiff and Vale. Audit findings demonstrate strong performance in recognising dying patients, documenting discussions regarding hydration, prescribing anticipatory medications and delivering individualised care planning. The Health Board compares favourably with Welsh and UK benchmarks across a number of these measures and provides seven-day specialist palliative care access with out-of-hours advice arrangements.

The audit demonstrated that the UHB recognition of end of life, documentation around hydration plans, prescribing of anticipatory medicine all exceeded 90% compliance and exceeded national performance in the acute hospital setting, however compliance was lower in community hospital sites. 100% of patient has a face to face specialist palliative care involvement in both acute and community hospital sites. Documentation of patients who died who had ethnicity recorded requires further focus with 83% of patients in acute wards and 33% of patients in community ward meeting this measure limiting the ability to assess equity of care.

The audit identifies opportunities for improvement around data quality, documentation and patient experience measurement. In addition, Cardiff and Vale has not historically undertaken the bereavement survey element of the audit, resulting in gaps within publicly reported patient and family experience measures. This presents both a reputational and governance risk as national patient and carer reporting tools become increasingly accessible to the public.

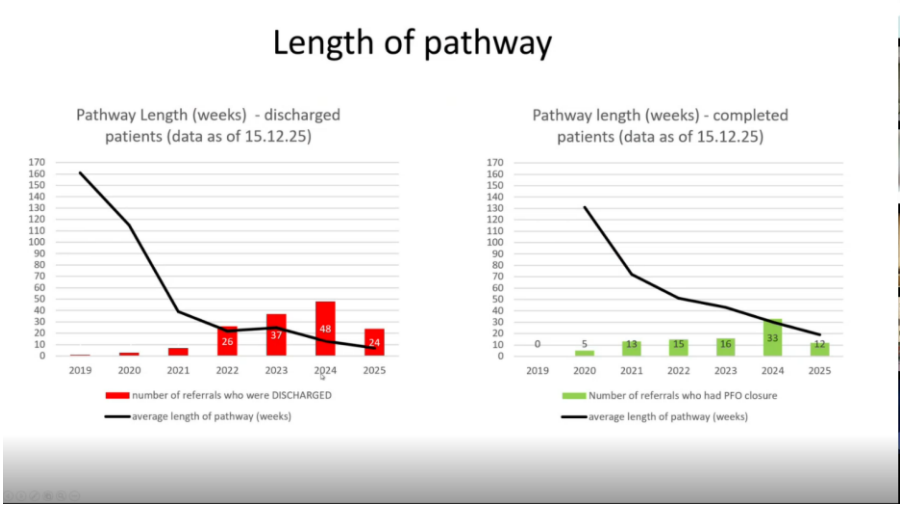
Significant improvement activity is underway. A new Palliative Care Strategy supported through the Macmillan Social Finance Programme is strengthening governance and quality improvement arrangements. Digital functionality to support advance care planning documentation has been introduced through the Welsh Clinical Portal, alongside innovative QR wristband technology to improve accessibility of patient preferences across care settings. The "Every Moment Matters" initiative has been rolled out across the Health Board to improve dignity and awareness at the end of life, while palliative care champions and enhanced multidisciplinary education programmes are being developed to strengthen workforce capability. Work is also progressing with patient experience and bereavement services to establish mechanisms for collecting family feedback and supporting future public reporting requirements.

## Patent Foramen Ovale (PFO) Service Audit

The Patent Foramen Ovale Closure (PFOC) Registry report was published in 2025 and relates to information relating to care provided in 2023/2024. The UHB did not submit any data or contribute to the the national audit despite being one of 20 units undertaking the procedure in the UK. This has since been rectified and Cardiff data is now being submitted and will be included in the 2026 audit publication.

The regional PFO service  provides an effective specialist intervention for the prevention of recurrent stroke and other serious embolic events. Audit findings demonstrate increasing service maturity, improved referral quality and a low complication rate. The service has established multidisciplinary arrangements including  Cardiology, Neurology and Hamatology, and provides access across South and Mid Wales. Closure procedures remain highly effective and are associated with substantial reductions in future stroke risk for appropriately selected patients.

The principal risks relate to service capacity and pathway delays. Whilst referral quality has improved, patients continue to experience waits associated with the complexity of investigations and multidisciplinary assessment.  There is also an ongoing need to ensure referring clinicians complete comprehensive investigations prior to referral to avoid unnecessary delays and the charts below demonstrate improvements in pathway efficiency.




The service has implemented a redesigned referral pathway and dedicated coordination arrangements, resulting in improved referral quality, increased closure rates and reduced unnecessary demand on multidisciplinary meetings.

Audit submission processes have also been strengthened following previous under-reporting to the national database and complete prospective data collection is now in place. Further work will focus on reducing pathway duration strengthening multidisciplinary support and improving access for patients who would benefit from this preventative intervention.

| **Appendices:** | | | |
|---|---|---|---|
| **NA** | | | |
| **Strategic Alignment – Shaping Our Future Wellbeing:** | | | |
| Putting People First | | Providing Outstanding Quality | **x** |
| Delivering in the Right Places | | Acting for the Future | |

| **Impact Assessment** |
|---|
| **Risk**: Yes |
| *Data collection issues in some audits means that the UHB can not reliably benchmark the organization* |
| **Safety**: Yes |
| *Full participation in national audits allows oversight of safe and effective clinical care provision and national benchmarking* |
| **Financial**: No |
| **Workforce**: Yes |
| *National audits include oversight of workforce measures including resource and training* |
| **Legal**: No |
| **Reputational**: Yes |
| *Failure to participate in full in the NCAORP risks undermining the UHB repoutation* |
| **Socio Economic**: No - *https://www.gov.wales/socio-economic-duty-guidance* |
| **Equality & Health**: Yes |
| *The national audits frequently provide insight into health inequalities – the Paediatric Diabetes Audit clearly highlights variation in outcomes influenced by deprivation.* |
| **Decarbonisation**: No |
| **Welsh Language**: No |

| | | | | | |
|---|---|---|---|---|---|
| Report Title: | Regulation 28 Prevention of Future Deaths Report –Health Board Response and Assurance Arrangements | | Agenda Item No: | | 3.5 |
| Meeting: | Quality Committee | Public | x | | 28.07.2026 |
| | | Private | | | |
| Lead Executive Title: | Executive Nurse Director | | | | |
| Report Author/s Title: | Assistant Director of Patient Experience | | | | |

Report Focus Summary – AAA Framework:
*The AAA framework reflects the overall position of the matter being reported. Select one category only and complete the relevant box with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

The Committee is asked to receive assurance regarding the Health Board's response to the Regulation 28 Report to Prevent Future Deaths issued following the inquest into Lisa Townsend. The Coroner identified concerns regarding the absence of a clearly defined escalation and referral protocol for HPB patients requiring specialist tertiary input and delays in obtaining specialist advice and transfer.

The Health Board has undertaken immediate actions to reinforce consultant-to-consultant escalation arrangements, strengthen awareness of referral expectations, and promote timely specialist consultation and transfer where clinically indicated. Further work is underway to formalise regional escalation pathways, define referral triggers and timescales, strengthen governance oversight and embed learning through audit and review processes.

The Committee is provided with assurance that the identified risks are recognised, actions have commenced, and governance arrangements are in place to oversee implementation and monitor compliance

The Committee can be assured that a formal response to the Coroner has been developed, immediate learning actions have been implemented, and further work is underway to establish a documented regional HPB escalation framework with ongoing governance oversight and audit arrangements

| Board/Committee Response Required *(please select only one)* | | | | | |
|---|---|---|---|---|---|
| Assurance | X | Approval | | Information/Noting | |

Recommendations:

- **Note** the contents of the Coroner's Regulation 28 Report and the concerns raised.

☐ **Receive assurance** regarding the actions already implemented by the Health Board.
☐ **Endorse** ongoing governance oversight through appropriate clinical governance structures.

| Governance Route *(please list all other Committee/Groups this report has been to)* | |
|---|---|
| *Where it's been:* | ☐ *Inquest Learning Review and scrutiny panel*<br>☐ *Surgical Clinical Board Governance Arrangements*<br>☐ *Executive Review of Regulation 28 Response* |
| *When it went:* | |
| *What decision was made:* | *Recommended to Quality Committee for assurance and oversight.* |

Main Report
*Background & Current Situation*

The Coroner issued a Prevention of Future Deaths Report on 6 May 2026 following the inquest into Lisa Townsend. The report was sent to Cardiff and Vale University Health Board, Cwm Taf Morgannwg University Health Board and Welsh Government.

The Coroner identified concerns that there was no established protocol defining when escalation should occur from a local hospital to the tertiary HPB centre, resulting in delays in specialist advice and transfer. The Coroner concluded that unless action was taken there remained a risk of future deaths

The Health Board's response acknowledges the need for greater clarity and consistency in regional escalation arrangements and sets out actions already taken and additional improvements planned. These include reinforcing existing escalation expectations, educational activities, formalising referral arrangements, engagement with regional partners regarding service configuration, and implementing governance oversight and audit

The response also highlights the current service context whereby specialist HPB expertise is available at University Hospital of Wales, but a formally commissioned regional emergency HPB on-call service is not currently in place. This can create reliance on informal referral arrangements rather than a single defined pathway.
The Committee is therefore asked to take assurance that actions are being progressed to reduce variation, improve escalation processes and strengthen patient safety.

Appendices:

- SWC regulation 28
- PFD response

Strategic Alignment – Shaping Our Future Wellbeing:

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

| Impact Assessment |
|---|
| Risk: Yes |

| |
|---|
| *The Coroner has identified a risk of future deaths should escalation and referral arrangements remain unclear. Actions within this report are intended to mitigate that risk through formalisation of pathways and strengthened governance oversight* |
| Safety: Yes |
| *The report directly relates to patient safety, timely access to specialist advice, escalation and transfer arrangements for patients requiring specialist HPB management* |
| Financial: Yes |
| *Potential future financial implications may arise from the development of formal regional arrangements and any future commissioned on-call HPB model. These remain subject to discussion with commissioning partners and Welsh Government.* |
| Workforce: Yes |
| *The response includes educational activity, reinforcement of escalation expectations and implementation of revised referral arrangements. These actions require staff awareness and compliance.* |
| Legal: Yes |
| *This report relates to statutory obligations arising under Regulation 28 and Regulation 29 of the Coroners (Investigations) Regulations 2013.* |
| Reputational: Yes |
| *Failure to respond effectively to the Coroner's concerns or demonstrate implementation of actions could adversely affect public confidence and organisational reputation. The proposed action plan seeks to mitigate this risk.* |
| Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance* |
| *No significant socio-economic impacts have been identified. The proposals are focused on clinical governance, escalation and patient safety arrangements.* |
| Equality & Health: No |
| *An Equality and Health Impact Assessment is not required at this stage. The actions seek to improve safe and equitable access to specialist care for all patients.* |
| Decarbonisation: No |
| *No significant decarbonisation implications identified* |
| Welsh Language: No |
| *The actions relate to clinical governance and patient safety. Existing Welsh Language Standards continue to apply to patient communication and service delivery.* |

**GRAEME HUGHES**

**HIS MAJESTY'S SENIOR CORONER**

**SOUTH WALES CENTRAL CORONER AREA**

**CORONER'S OFFICE**
**THE OLD COURTHOUSE**
**COURTHOUSE STREET**
**PONTYPRIDD**
**CF37 1JW**

**Telephone: 01443 281100**
**Email: Coroneradmin@rctcbc.gov.uk**

**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

*NOTE: This form is to be used **after** an inquest.*

| | |
|---|---|
| | **REPORT TO PREVENT FUTURE DEATHS**<br><br>**REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013**<br><br>Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026). |
| 1 | **CORONER**<br><br>I am **Patricia Morgan Area Coroner**, for the coroner area of South Wales Central. |
| 2 | **DATE OF REPORT 6th May 2026** |
| 3 | **CORONER'S LEGAL POWERS**<br><br>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. |

| | |
|---|---|
| 4 | **THIS REPORT IS BEING SENT TO**<br><br>1. Cwm Taf Morganwg University Health Board<br><br>2. Cardiff and Vale University Health Board<br><br>3. Cabinet Secretary for Health and Social Care in Wales, Welsh Government.<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st July 2026. I, the coroner, may extend the period if an appropriate application is made. |
| 5 | **YOUR RESPONSE**<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.<br><br>I have a duty to send a copy of your response to the Chief Coroner.<br><br>In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.<br><br>Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.<br><br>The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary. |
| 6 | **SUMMARY OF CORONER'S CONCERN**<br><br>During the inquest touching the death of Lisa Jayne Townsend, the Coroner heard evidence in respect of the absence of clear guidance and protocol for when a referral should be made by the local hospital (Princess of Wales, Bridgend) to the tertiary centre (University Hospital of Wales) in respect of Hepato-Pancreato-Biliary (HPB) related matters. There was a delay in advice being sought from and transfer to the tertiary centre taking place. There remains no established protocol to assist Clinicians with when they should escalate and seek further specialist advice from their tertiary centre to ensure timely consideration of the patient's issue. |

| | |
|---|---|
| | **ACTION SHOULD BE TAKEN** |
| 7 | In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action. |
| | **INVESTIGATION AND INQUEST**<br><br>**On 26/09/2025 I commenced an investigation into the death of Lisa Jayne Townsend. The investigation concluded at the end of the inquest on 17/04/2026.**<br><br>**The medical cause of death was:**<br><br>**1a Sepsis**<br><br>**1b Chyolecystitis (operated 01/10/2024)**<br><br>**1c**<br><br>**1d**<br><br>**II**<br><br>**The circumstances were :-** |
| 8 | Mrs Lisa Jayne Townsend had been unwell since early August 2024 with abdominal pain. It was identified in late September 2024 that she was suffering with cholecystitis and pancreatitis, necessitating surgical intervention to remove her gall bladder. This surgery was delayed but took place on 1 October 2024, during which an injury was sustained to the bile duct. Multiple attempts to rectify the injury via an ERCP took place over the coming weeks which were unsuccessful.<br>Mrs Townsend was transferred to University Hospital of Wales, Cardiff on 20 November 2024. There, further surgical intervention took place. Ultimately, Mrs Townsend was unable to overcome chronic sepsis and she was overwhelmed by infection. She died on 20 March 2025 at University Hospital of Wales, Cardiff.<br><br>There were multiple delays and issues in Mrs Townsend's care, along with the injury sustained in the surgery of 1st October 2024 which more than minimally contributed to her death.<br><br>**<u>Conclusion:</u>** |

| | |
|---|---|
| | Mrs Townsend died as a result of bile duct injury and complications arising from delayed surgery. |
| 9 | **CIRCUMSTANCES OF DEATH**<br><br>See box 8 above |
| 10 | **CORONER'S CONCERNS**<br><br>During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows:<br><br>See box 6 above |

| | |
|---|---|
| 11 | **COPIES AND PUBLICATION OF THIS REPORT**<br><br>I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.<br><br>I also may send a copy of the report to any other person who I believe may find it useful or of interest.<br><br>I can confirm I have sent the report to:<br><br>*[please do not use individual's names, but instead roles/titles]*<br><br>1. Cwm Taf Morganwg University Health Board<br><br>2. Cardiff and Vale University Health Board<br><br>3. Cabinet Secretary for Health and Social Care in Wales, Welsh Government.<br><br>I also have a duty to send a copy of the report to the Chief Coroner.<br><br>You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses. |

6 May 2026

**SIGNED:** 

Patricia Morgan Area Coroner for South Wales Central Coroner Area

Chief Coroner

Coroner's Office, The Old Courthouse, Courthouse Street, Pontypridd, CF37 1JW

Phone/Ffôn (01443) 281100 Fax/Ffacs (01443) 485862

**RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS**

**REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013**

When a coroner sends a prevention of future deaths (PFD) report to a person or organisation, they must respond within 56 days. Recipients of a PFD report can apply to the coroner for an extension. A response to a PFD report must detail the action taken or to be taken, whether in response to the report or otherwise, or it must explain why no action is proposed.

The purpose of the response template below is to promote clarity, ensure that responses address the coroner's concerns directly and transparently, and support consistency and good practice across organisations and sectors.

It does not restrict how a person or organisation formulates their response; recipients remain responsible for determining what action is appropriate and for ensuring that their response accurately reflects the steps taken or planned.

In accordance with the Chief Coroner's PFD Publication Policy (2026),any representations regarding publication of a response should be sent to the coroner. These representations should be made at the same time as the response is provided. The coroner will pass any representations received to the Chief Coroner for a decision.

**RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS**

**REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

THIS RESPONSE IS BEING SENT TO:

**The Senior Coroner, [X] for the Coroner Area [X]** in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28'** following an inquest into the death of [**NAME OF DECEASED]** that concluded on **[DATE]**.

**RESPONDENT**

1. In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, **NAME** provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.
2. **DATE OF RESPONSE**
   **CONFIRMATION OF CORONER'S MATTERS OF CONCERN**

   The **MATTERS OF CONCERN** were identified in the report are as follows:

3.

   **DETAILS OF ACTION TAKEN,** how has the concern been addressed.
   [If no action is proposed please explain why here].

   *Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.*

3.

| | |
|---|---|
| | **DETAILS OF FURTHER ACTION PROPOSED**<br>*Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.*<br>4.<br><br>**SIGNATURE** |

Coroner's Office, The Old Courthouse, Courthouse Street, Pontypridd, CF37 1JW

Phone/Ffôn (01443) 281100 Fax/Ffacs (01443) 485862

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

Woodland House
Maes-y-Coed Road
Cardiff
CF14 4HH

Ty Coedtir
Ffordd Maes-y-Coed
Caerdydd
CF14 4HH

Eich cyf/Your ref:
Ein cyf/Our ref:
Welsh Health Telephone Network:
Direct Line/Llinell uniongychol: 02921 83----

H.M. Patricia Morgan
Area Coroner
South Wales Central
Coroner's Office
The Old Courthouse
Courthouse Street
Pontypridd
CF37 1JW

16 June 2026

**Email: Coroneradmin@rctcbc.gov.uk**

Dear Ms Morgan,

On behalf of Cardiff and Vale University Health Board, thank you for your Regulation 28 Report issued on 6 May 2026 following the inquest into the death of Lisa Jayne Townsend. We again extend our sincere condolences to Ms Townsend's family. The Health Board recognises the purpose of the Report is to identify matters giving rise to a risk of future deaths and to secure a clear response setting out the action taken and the further action proposed.

1. **Confirmation of the Coroner's matters of concern**

The Health Board understands the Coroner's concern to be that there was an absence of clear guidance and protocol as to when referral should be made from the local hospital to the tertiary HPB ( Hepato Biliary) centre in relation to HPB conditions, that there was delay in specialist advice being sought and in transfer taking place, and that there remains no sufficiently established protocol to assist clinicians in identifying when escalation to tertiary HPB advice and transfer should occur.

2. **Position of the Health Board in response to that concern**

The Health Board accepts that, in this case, there was delay in escalation from the treating Health Board ensuring referral for specialist HPB input, and it acknowledges the importance of ensuring greater clarity and consistency in regional referral arrangements for patients with suspected bile duct injury and other complex benign HPB pathology. At the same time, the Health Board considers it important to distinguish between a lack of clinical principles and a lack of formal commissioning arrangements. The management of suspected bile duct injury is guided by established national and international clinical standards which support early recognition, prompt discussion with a specialist HPB centre at the point of suspicion, and transfer where required for definitive expert management. These principles are embedded in surgical training and are recognised as standard practice. This is consistent with the position already set out in the current draft response.

The Health Board also wishes to clarify the current service context. The HPB team at University Hospital of Wales provides a highly specialised tertiary HPB service; however, that service is not formally commissioned or funded as a regional emergency HPB on-call service for conditions such as bile duct injuries and complex benign HPB pathology. Notwithstanding that absence of formal commissioning, the service is routinely approached by other Health Boards for specialist HPB advice and management. The Health Board's position is therefore that specialist expertise is available and is accessed, but the absence of a commissioned regional on-call model can result in over-reliance on informal pathways rather than a single formally defined regional referral route. This reflects and develops the commissioning point already included in your current draft.

The Health Board further notes that there have been prior occasions on which patients with suspected bile duct injury have been referred to the HPB service in a timely way from the same Health Board, including from the same clinical source. The Health Board therefore considers that the principal issue arising from this case was not the absence of specialist knowledge or the impossibility of access to specialist advice, but rather the failure to apply established escalation principles promptly and consistently in this specific instance.

### 3. Action already taken

In response to the concern identified, the Health Board has reviewed the issues raised in relation to regional escalation to specialist HPB services. Immediate work has been undertaken to reinforce the existing expectation that suspected bile duct injury and comparable complex benign HPB cases should trigger early consultant-level discussion with the tertiary HPB centre at the point of suspicion, including where concern arises intra-operatively or in the post-operative period. This aligns with the emphasis in your current draft on early identification, timely specialist consultation and appropriate transfer.

The Health Board has also taken steps to remind relevant partners of the existing escalation framework for HPB complications, including the need for urgent advice to be sought promptly and for transfer to be considered without avoidable delay where specialist tertiary management is indicated. As reflected in the current draft, this includes reinforcing designated contact avenues, urgent advice procedures and the importance of timely escalation.

In addition, focused communication and educational activity is being used to reinforce the existing clinical principles underpinning referral and escalation for suspected bile duct injury. The purpose of this action is to reduce unwarranted variation in practice, strengthen clinician awareness of when specialist input should be sought, and support more reliable application of recognised standards across organisational boundaries.

### 4. Further action proposed

To address the Coroner's concern more explicitly and transparently, the Health Board proposes further work to move from reliance on recognised but partly informal arrangements to a more clearly documented regional framework. This will include the

development and dissemination of a formalised escalation and referral framework for suspected bile duct injury and other relevant complex benign HPB pathology, setting out referral triggers, expected timescales for consultant-to-consultant discussion, contact arrangements, and expectations regarding transfer where tertiary management is required. This builds directly on the current draft's commitment to improve clarity and consistency through more formal frameworks.

The Health Board also intends to continue engagement with regional partners, Welsh Government and relevant commissioning bodies regarding the current service model. As already acknowledged in your draft, the absence of a commissioned regional HPB on-call rota creates avoidable ambiguity in identifying a single point of referral. The commissioning of a defined regional emergency HPB on-call function would provide greater clarity, strengthen accountability, reduce reliance on informal routes, and support more consistent and timely access to specialist expertise. The current draft expressly notes that commissioning the on-call rota would be welcomed to address and mitigate related risks.

The Health Board will additionally ensure that the learning from this case is embedded through governance processes, with oversight of implementation through the appropriate clinical governance structure, including confirmation that the revised escalation arrangements have been communicated and that compliance can be tested through audit or case review. This expands the assurance language already present in your draft that the Health Board remains committed to enhancing educational initiatives and reinforcing assurance processes.

## 5. Conclusion

The Health Board recognises the seriousness of the issues identified by the Coroner and is committed to taking proportionate action to reduce the risk of recurrence. In summary, the Health Board's position is that the clinical principles governing early referral of suspected bile duct injury are established and understood, but that this case has highlighted the need to strengthen the consistency, formality and assurance of regional escalation arrangements.

The actions already taken and the further actions proposed are intended to improve clarity of access to specialist HPB advice, reduce variation in referral practice, and support safer and more timely escalation for future patients.

We assure you of our full cooperation and dedication to implementing the stated actions. If further information or clarification is required, please do not hesitate to contact us.

Yours sincerely,

Jason Roberts
**Executive Nurse Director**
**Cardiff and Vale University Health Board**

| | | | | | |
|---|---|---|---|---|---|
| Report Title: *(needs to match agenda)* | Public Health Work 6 Month Update (including Targeted Intervention Indicators) | | | Agenda Item No: | 5.1 |
| Meeting: | Quality Committee | Public | X | Meeting Date: | 28 July 2026 |
| | | Private | | | |
| Lead Executive Title: | Executive Director of Public Health | | | | |
| Report Author/s Title: | Consultant in Public Health Medicine | | | | |

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

**ALERT** *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

**ADVISE** *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

**ASSURE** *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

This paper provides assurance on the performance and delivery of public health interventions in Cardiff and the Vale of Glamorgan, highlighting recent performance of note, and actions recently undertaken.

Our public health programme is set within the context of the Health Board's long-term public health plan, with its priorities for 2024-2028 of immunisation, smoking cessation and healthy weight.

| **Board/Committee Response Required *(please select only one)*** | | | | | |
|---|---|---|---|---|---|
| **Assurance** | X | **Approval** | | **Information/Noting** | |

**Recommendations**

The Quality Committee is asked to:

- **Note** the context of the Cardiff and Vale long-term public health plan, and the current priorities for public health in Cardiff and the Vale
- **Note** current performance and delivery of public health programmes in our area
- **Note** this is the first of regular six-monthly updates on our public health programmes

**Governance Route *(please list all other Committee/Groups this report has been to)***

| | |
|---|---|
| ***Where** it's been:* | n/a |
| ***When** it went:* | |
| ***What** decision was made:* | |

**Main Report**

*Background & Current Situation*

The Cardiff and Vale UHB long-term public health plan was developed and published in 2024. This gives a summary of the population demographics and health needs of the population of Cardiff and Vale, along with a vision for public health for Cardiff and the Vale, and the rationale for prioritising prevention.

Over 500,000 people live in Cardiff and the Vale, with the number of people living here increasing steadily each year. There are significant inequalities in health within our area, with women in our most deprived areas experiencing on average 17 fewer healthy years of life than those in our least deprived areas, and men living 9 fewer years overall.

Over a fifth of deaths in England and Wales are avoidable due to preventable or treatable conditions, and public health interventions on average return £14 to the public purse for every £1 spent.

The long-term plan sets out three phases of action up to 2035, with priorities for those phases developed in the run up to each starting, to ensure the plan can be flexible and responsive to changing circumstances.

In the first phase of the plan (2024-2028) the priorities for public health in Cardiff and the Vale were agreed as immunisation, smoking cessation, and healthy weight ('the big three'). These priorities were chosen as they would have the biggest impact on reducing inequalities in our population. Throughout the plan period we will continue to develop and maintain a strong health protection system.

Over the next 12 months we will start to review the priorities for the second phase of the plan, from 2028 to 2031.

Alongside the long-term plan we set out an annual public health plan with priorities, milestones and key performance indicators for the year ahead, as part of the Health Board's annual planning cycle.

A number of actions and measures in our priority areas feature in the NHS Wales performance framework and key delivery expectations. As such we regularly report performance for these in the Health Board Integrated Performance Report (IPR), as well as providing updates against the milestones in our annual plan as part of the Health Board's routine reporting. There are also public health measures in the Health Board's agreed Escalation Framework with Welsh Government as part of Targeted Intervention, and we report regularly on those.

This report is the first of a regular six-monthly update to Quality Committee to highlight current public health performance and actions undertaken. This will include a copy of our latest submissions for the Integrated Performance Report and Escalation Framework, with key metrics and actions highlighted below.

**Current situation**

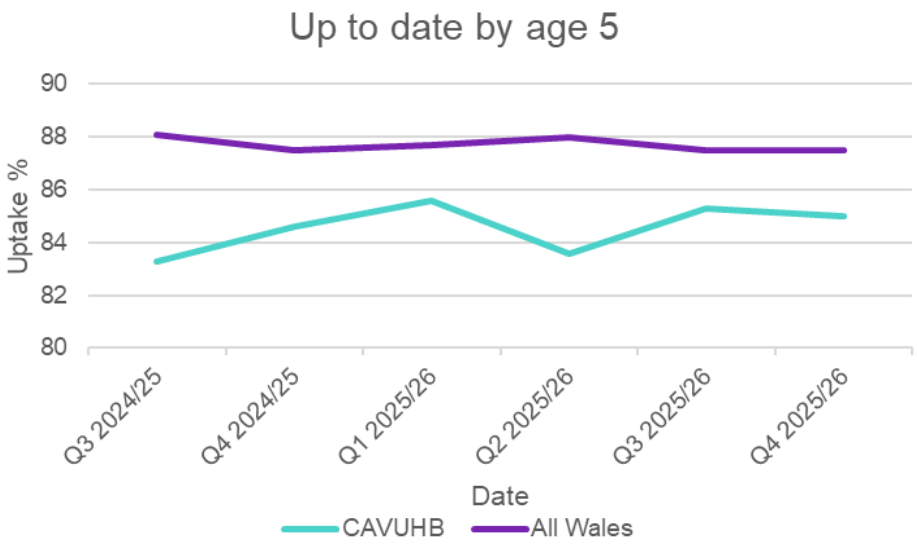
The Escalation Framework contains the following metrics which fall under the responsibility of the Public Health Team:

- Percentage of children up to date with scheduled vaccinations by age 5 to be in line with the all-Wales average.
- HPV vaccine uptake rate for children by the age of 15 to be in line with all Wales average.
- Percentage of adult smokers who make a quit attempt via smoking cessation services towards the target compliance over the 12-month period measure.
- Positive action taken in response to the alarm outlier in the National Paediatric Diabetes Audit 2023-24 for adjusted mean HbA1c (30.5%).

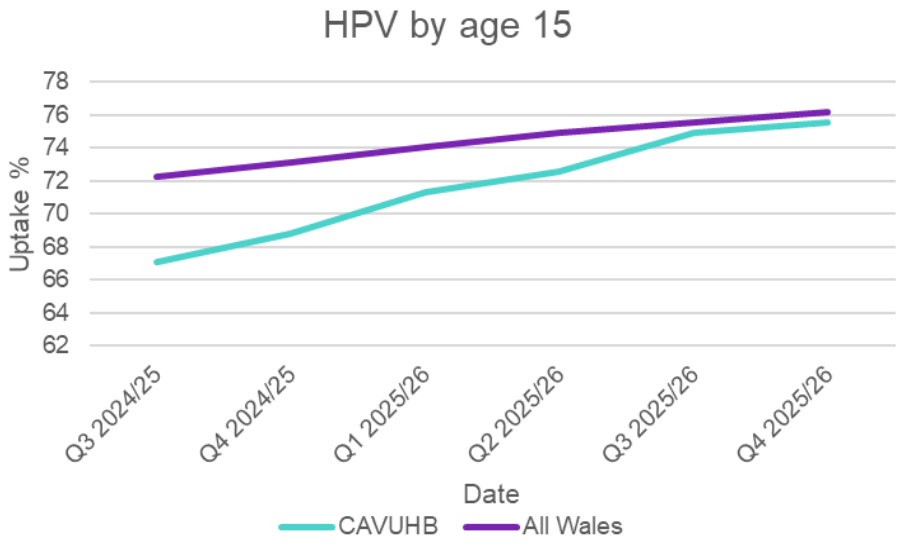
Detailed information on our performance is given in the Appendix. (To note the format of the Health Board Integrated Performance Report was being significantly changed for the July 2026 report with the final version not available at the time of finalising this report, so we have attached a copy of the public health sections in the format of the old report.)

Key areas of performance for awareness include:

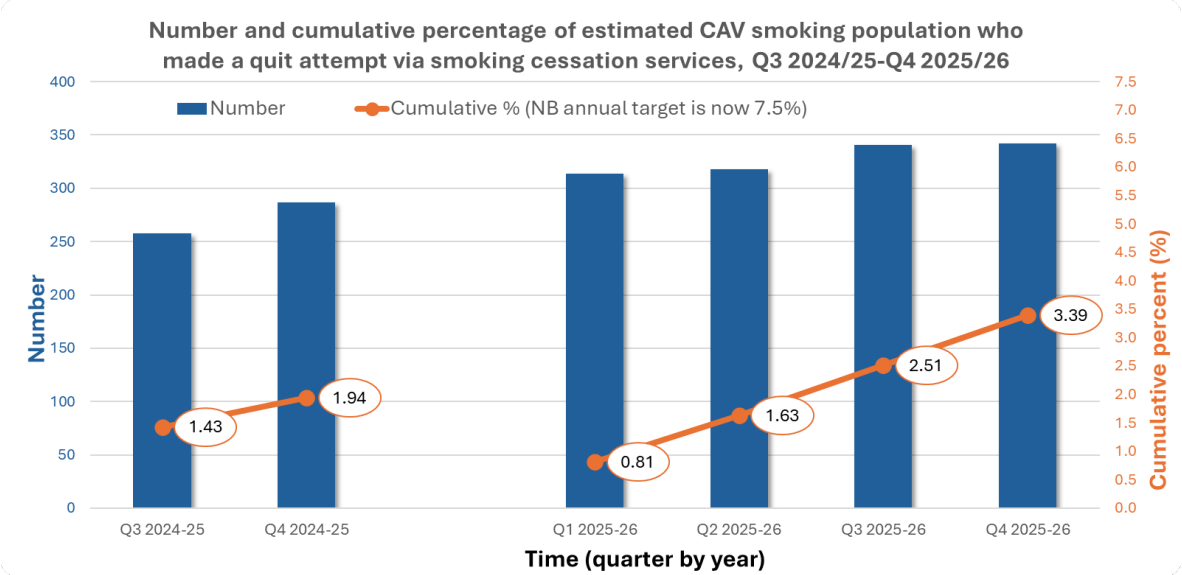
- Immunisation
    - For 1 January to 31 March 2026, **79.9%** of children were up to date with vaccination by age 4, and **85%** of children were up to date by age 5




- For the RSV catch-up programme (resident population aged 75 to 79 as of 1 September 2024), 13,645 out of 18,177 individuals have been vaccinated to date. This is an uptake of **75.1%**, which is above the All-Wales average of 71.8% and the highest uptake across Health Boards in Wales.
- For 1 January to 31 March 2026, uptake of HPV vaccine for children reaching 15 years of age was **75.6%**, an increase on the previous quarter (74.9%) (see graph below)




- Smoking cessation
  - The cumulative percentage of the estimated smoking population who made a quit attempt via smoking cessation services increased from 1.94% in Q4 2024/25 to 3.39% in Q4 2025/26, though this remains below the target of 5% (2025/26) and the new target of 7.5% from April 2026




- Healthy weight
    - 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.
- Diabetes
    - Most recent data (Q1 26/27) shows a reduction in the gap between highest and lowest uptake rates of all 8 care processes at cluster level compared to baseline (18.7% gap, from 27.2% Dec 25). The Q4 25/26 gap was 25.8%
    - The Health Board Paediatric Diabetes Unit has moved in a positive direction from 'alarm' status to 'alert' status in most recent National Paediatric Diabetes Audit report (2024-25 data)

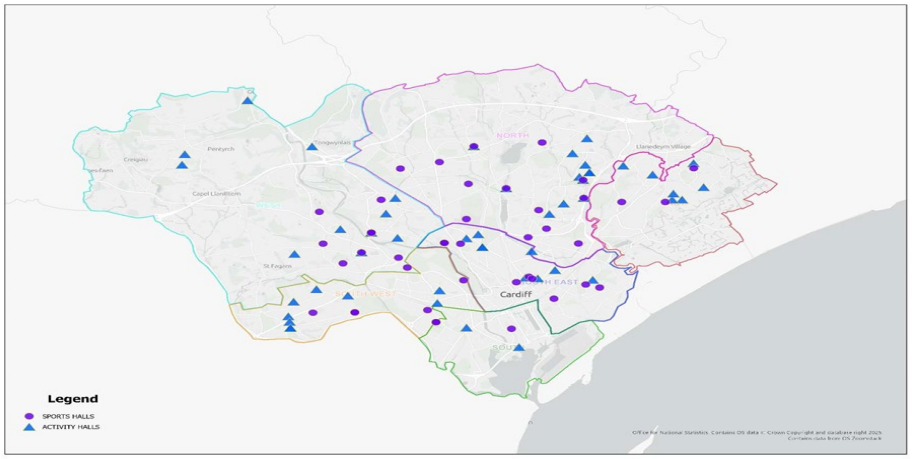
Recent actions undertaken as part of our public health work include:

- Immunisation
    - The Childhood & Teenage Immunisations Strategic Action Plan is complete, pending approval from the Quality Committee in July 2026. The strategy is for a period of 3 years and the first-year delivery plan has been developed collaboratively across all partners delivering health board vaccination programmes and in consultation with primary care. There is a strong focus on improving uptake of all vaccines by age 5 and uptake of HPV by age 15.
- Smoking cessation
    - Targeted service promotion has resulted in an increase in Help Me Quit activity. In May 2026 the number of smokers treated by the Help Me Quit service increased by 50% compared with the same month last year.
    - The Allen Carr Easy way project provided a stop smoking intervention to 93 smokers between 1.4.26 and 3.07.26
    - The Help Me Quit community smoking cessation team is present in University Hospital Llandough 2 days each week to offer smoking cessation support to in-patients, staff and visitors.
    - The Smoking enforcement officer has approached 1380 individuals found smoking on hospital sites, between 17.11.25 and 17.5.26. An evaluation was completed in June 2026 which will inform the next stage of the project
- Healthy weight
    - The Cardiff Physical Activity and Sport **Facility Audit Report** is complete. It provides a comprehensive assessment of all places that support physical activity, from playgrounds, parks, and grass pitches to community halls, leisure centres, and elite sporting facilities, and more. It establishes a robust evidence base on the availability, quality, accessibility, and distribution of facilities, identifying gaps and inequalities in provision.
    - Findings include: Cardiff offers a wide range of sports and recreation facilities, including major venues, community halls, gyms, parks, and informal spaces, but access is uneven, with significant inequalities in provision, quality, and affordability. Inner-city and disadvantaged communities face

the greatest challenges due to shortages of open space, overused facilities, high costs, travel barriers, and limited access to school facilities.

- Here is an example of one facilities audit map:

*Figure 4: Map of all Sports Halls and Activity Halls*




## Appendices:

1. Integrated Performance Report – public health elements of cover slides and data slides (please see note about format of the report under 'Current situation', above)

2. Targeted intervention slides showing smoking cessation and immunisation performance

## Strategic Alignment – Shaping Our Future Wellbeing:

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

## Impact Assessment

**Risk**: No

**Safety**: No

**Financial**: Yes

Financial pressures due to ever increasing population healthcare demand require a 'left shift' to investing in prevention, to reduce ill health in our wider population.

**Workforce**: No

**Legal**: Yes

Cardiff and Vale UHB has a statutory duty to protect and improve the health of the population, as well as provide healthcare for people who are unwell.

**Reputational**: No

**Socio Economic**: Yes - *https://www.gov.wales/socio-economic-duty-guidance*

The long-term Public Health Plan sets out as a cross cutting theme the need to reduce inequalities in health in our population

**Equality & Health**: No

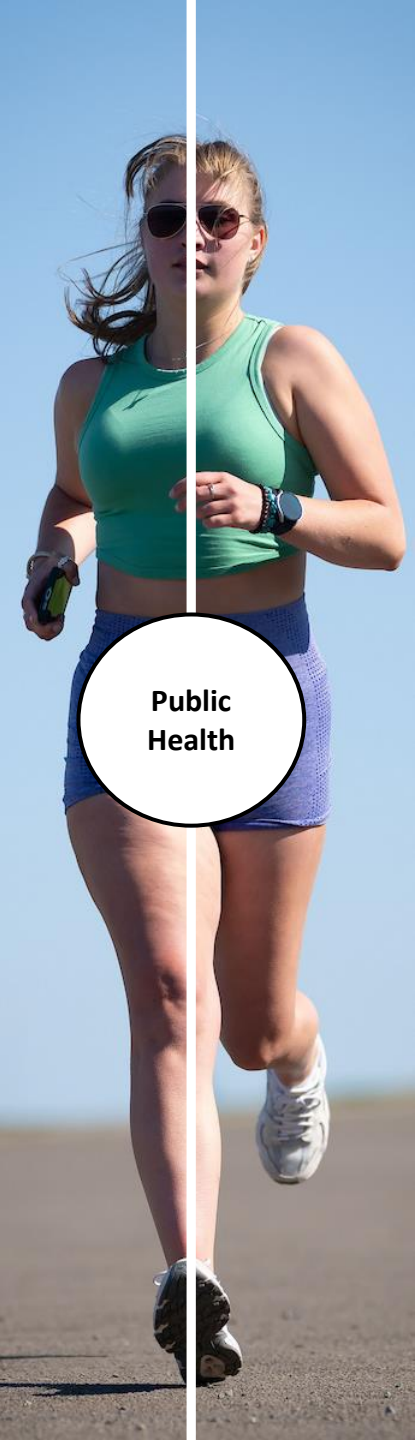
**Decarbonisation**: Yes

A significant proportion of Health Board carbon emissions are associated with secondary and specialist care for our patients. By supporting our population to be healthier, this will reduce healthcare demand and reduce carbon emissions

**Welsh Language**: No

# CARDIFF & VALE UHB
# INTEGRATED PERFORMANCE REPORT COVER PAPER – PUBLIC HEALTH JULY 2026

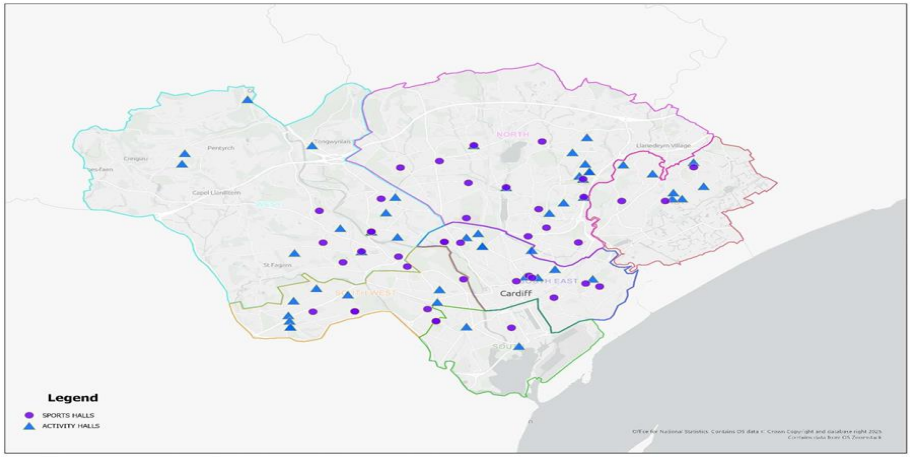

Finance
Public Health
Operational
Quality, Safety & Experience
People and Culture
Digital
Capital
Conclusion

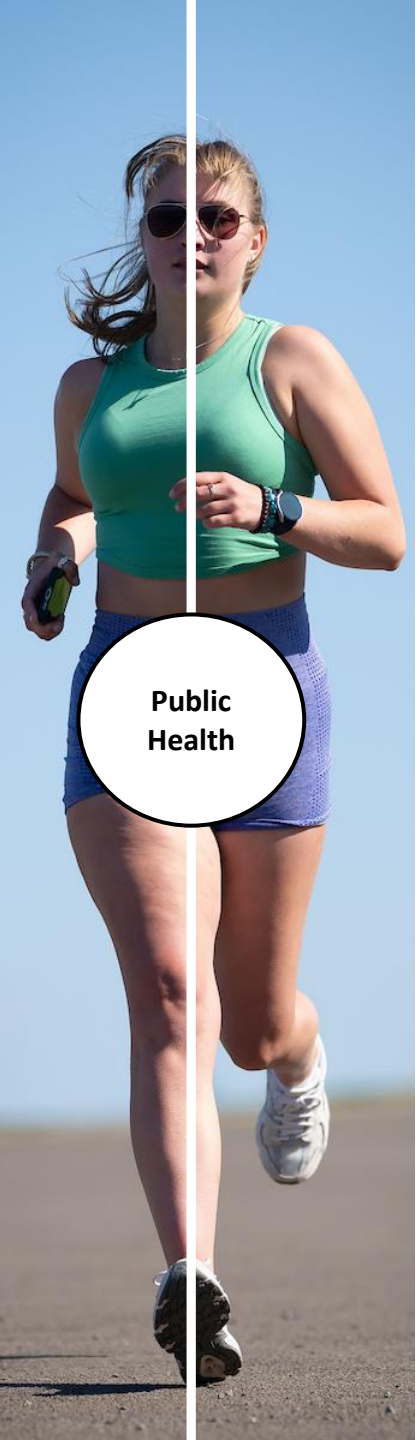



## Obesity

- The evidence base is clear that a Whole System Approach to tackling obesity is what makes a difference. We are making progress on this, but this is slow due to limited resources. A full business case to implement at scale and pace has not been funded due to the financial pressures on the organisation. This limits progress on this important public health agenda.
- Our joint **Good Food and Movement Implementation Plan** (2026-28) which describes the actions needed to keep our whole system approach to tackling obesity moving forward was discussed and agreed at Cardiff Leadership and Enabling Change Group on 28th April 2026. The plan was also agreed at the Vale of Glamorgan Senior Management Team on 16th June 2026.
- Cardiff Physical Activity and Sport **Facility Audit Report** is complete. It provides a comprehensive assessment of all places that support physical activity, including playgrounds, parks, grass pitches, community halls, leisure centres, and elite sporting facilities. It establishes a robust evidence base on the availability, quality, accessibility, and distribution of facilities, identifying gaps and inequalities in provision.
- Findings include Cardiff offers a wide range of sports and recreation facilities, including major venues, community halls, gyms, parks, and informal spaces, but access is uneven, with significant inequalities in provision, quality, and affordability. Inner-city and disadvantaged communities face the greatest challenges due to shortages of open space, overused facilities, high costs, travel barriers, and limited access to school facilities.
- The audit will support decision-making on facility development, upgrades, investment, and future planning, ensuring decisions are informed by up-to-date evidence.
- The audit is also informing the new government's manifesto commitment to conduct a facilities audit of sport facilities in Wales. Vale of Glamorgan's facility audit is being undertaken.
- Here is an example of one facilities audit map:

*Figure 4: Map of all Sports Halls and Activity Halls*






## Tobacco

**Smoking Prevention**

- **Smoke-Free Ambassador Scheme** is a learner-led programme that encourages primary school pupils to become advocates for smoke-free living both within their school and beyond. Currently in the evaluation phase, schools are providing feedback which will inform expansion of the programme. A bilingual easy-read booklet has also been developed and will be tested in September 2026.
- **Food and Fun** – Smoking and vaping prevention activities will be part of this programme which offers free healthy meals and enrichment activities to children during the school Summer holidays.
- **Events** - Smoking and vaping prevention activities will be incorporated into supporting National play day in Cardiff (29/07) and the Vale (05/08)

**Smoking Cessation**

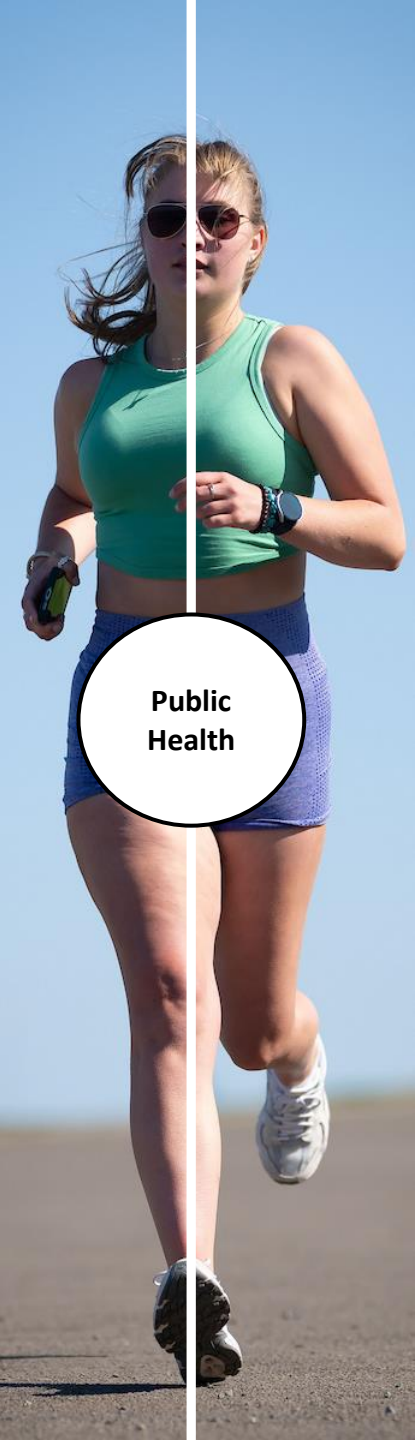
- Targeted service promotion has resulted in an increase in Help Me Quit activity. In May 2026, the number of smokers treated by the Help Me Quit service increased by 50% compared to the same month last year.
- Allen Carr Easy way project has provided a stop smoking intervention to 93 smokers between 1.4.26 and 3.07.26
- Help Me Quit community smoking cessation team will be present in the Pre Operative Assessment Clinic at University Hospital Wales on a weekly basis from July 2026 as part of a trial project. The aim is to offer smokers stop smoking support on the same day as their pre-op assessment and capitalise on a 'teachable moment'.
- Help Me Quit community smoking cessation team present in University Hospital Llandough two days each week to offer smoking cessation support to in-patients, staff and visitors.

**Smoke Free Environments**

- Smoking enforcement officer has approached 1380 individuals found smoking on hospital sites between 17.11.25 and 17.5.26 An evaluation was completed in June 2026 which will inform the next stage of the project.

## Women's Health Hubs

- A funding bid for pump-prime funding for Women's Health Hubs has been submitted to Welsh Government for consideration, following review by the Health Board's Value Based Realisation Group. The proposal has been informed through patient, staff and third sector engagement, and will support the Health Board's activities to meet the key delivery expectations.




## Vaccination – childhood vaccinations

**Children up to date with vaccinations**

- The Childhood & Teenage Immunisations Strategic Action Plan is complete, pending approval from the Quality Committee in July 2026. The strategy is for a period of 3 years and the first-year delivery plan has been developed collaboratively across all partners delivering health board vaccination programmes and in consultation with primary care. There is a strong focus on improving uptake of all vaccines by age 5 and uptake of HPV by age 15.

**Schools: Influenza. HPV and MMR**

- We have agreed with Cardiff and the Vale of Glamorgan Councils to establish task and finish groups to review the way in which schools engage with routine and catch-up vaccination programmes. This is based on learning from an MMR catch up programme delivered in 3 secondary schools between March and July 2026.

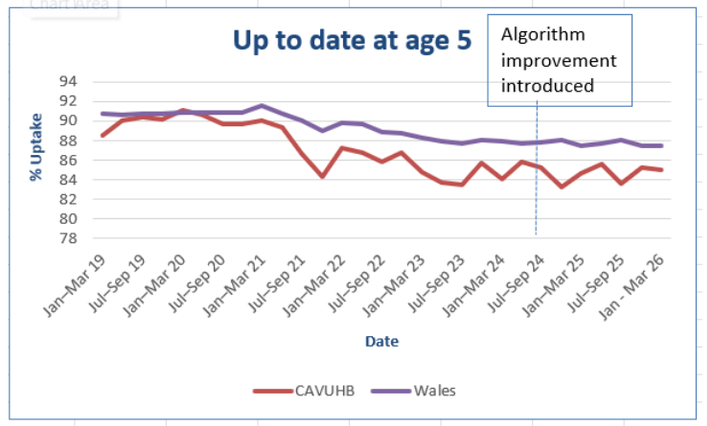
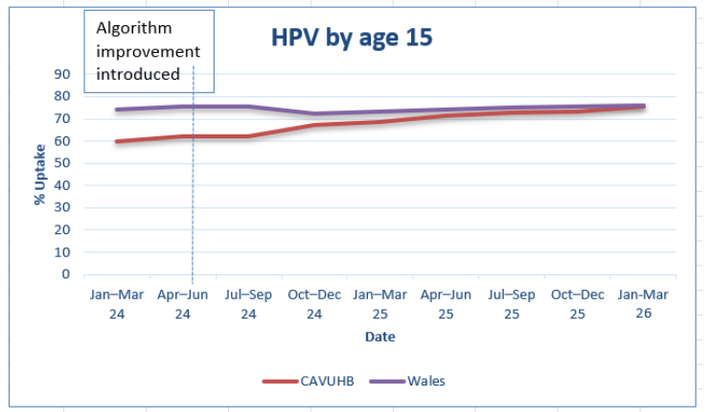
## Health protection

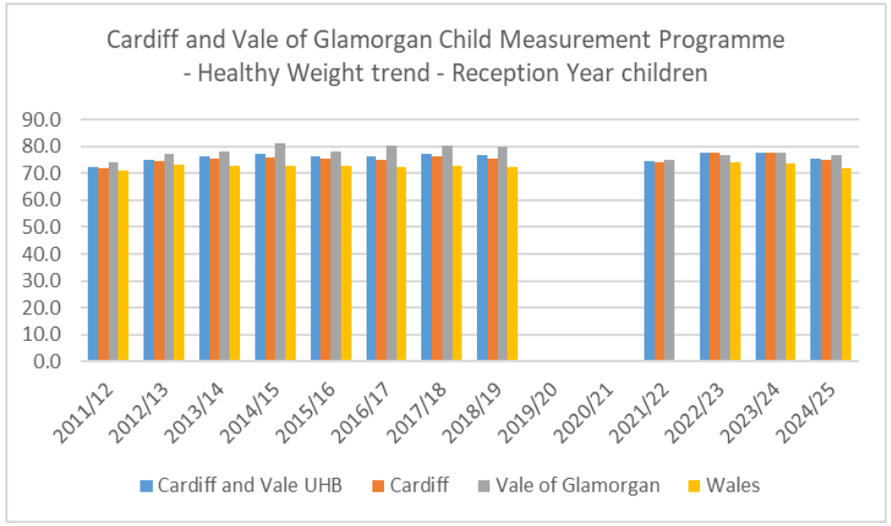
- The **Cardiff and Vale Health Protection Plan** is being reviewed, with engagement from partner agencies and health board teams. The new Plan will replace the existing 2024-2026 Plan and set the priorities for the health protection partnership over the next two years. The partnership includes CAVUHB, Cardiff and Vale of Glamorgan Councils, Shared Regulatory Service and Public Health Wales.

# Cardiff and Vale
# Integrated Performance Report

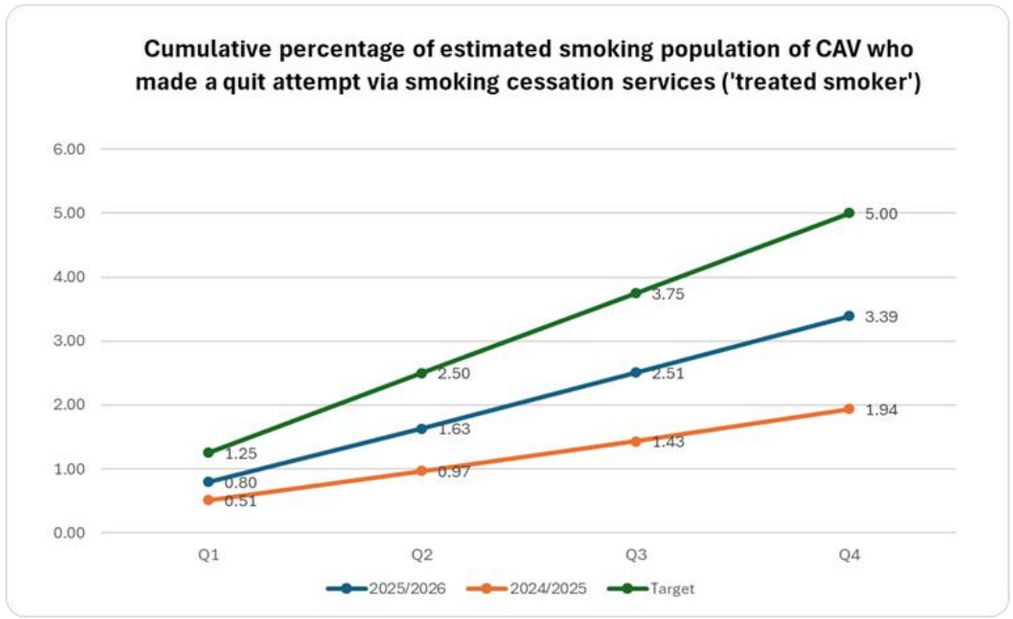
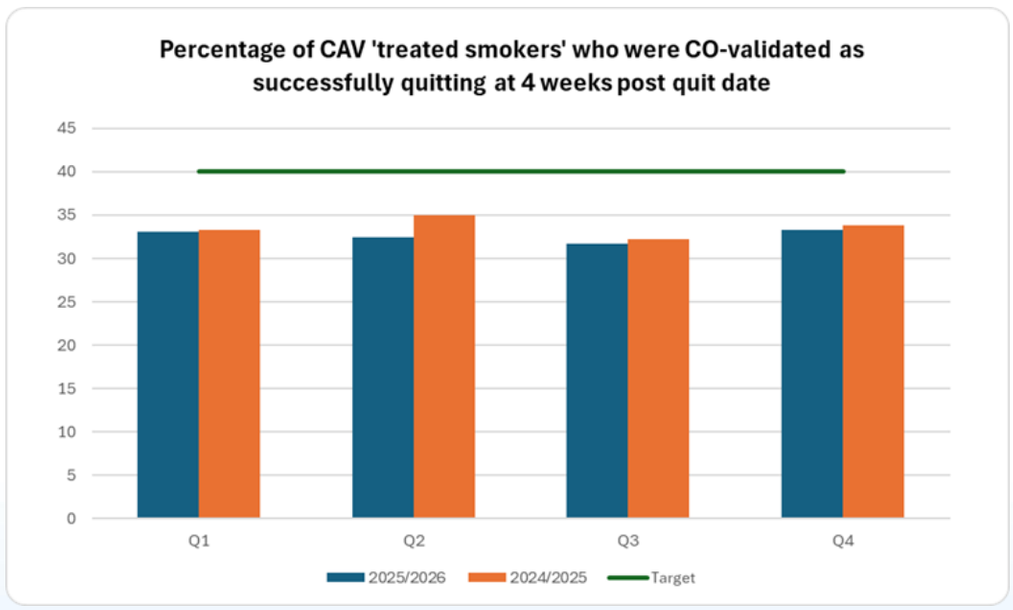
## July 26 Public Health update

| Priority | Performance Summary | Reported Period | On target? | Data |
|---|---|---|---|---|
| Health Protection | **Seasonal respiratory infections**<br><br>**Vaccination** – COVID-19, influenza and Respiratory Syncitial Virus (RSV)<br><br>The Spring COVID-19 campaign commenced 1 April 2026 (in Cardiff & Vale delivery commenced 13 April)<br>• As of 2 July 2026, 32,307 out of 58,533 individuals in the eligible population were vaccinated. This is an uptake of 51.6%, above the all-Wales average of 50.7%. The COVID-19 spring programme ended on 30 June 2026<br><br>• The Autumn **influenza** campaign commenced 1 September 2025 for health and social care staff under the age of 65, infants, children, young people and pregnant women. The programme commenced on 1 October 2025 for all other eligible population groups and concluded on 31 March 2026.<br>  • 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, but below the national target of 75%. There was a gap in uptake of 19% between the least and most deprived areas<br>  • 33,287 out of 74,852 residents in CAVUHB aged 16 to 64 years and at clinical risk were vaccinated. This is an uptake of 44.5%, above the all- Wales average of 43.2%. There was a gap in uptake of 13.7% between the least and most deprived areas<br><br>• 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. 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.<br><br>  • 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%. This is below the national target of 70%.<br><br>  • For the RSV catch-up programme (resident population aged 75 to 79 as of 1 September 2024), 13,645 out of 18,177 individuals have been vaccinated to date. This is an uptake of **75.1%**, which is above the All-Wales average of 71.8% and the highest uptake across Health Boards in Wales.<br><br>  • For the RSV expansion to adults aged 80+ as of 1 September 2024, uptake is 52.8% (June 2026 data) | COVID-19: 1 April – 2 July 2026<br><br>Influenza: 1 October 2025 – 31 March 2026<br><br>RSV: Routine cohort: 1 September 2025 – 31 May 2026<br><br>RSV: Catch up: 1 September 2024 - date | COVID-19: Below target<br><br>Influenza: Below local and national target.<br><br>RSV: Below national target.<br><br>RSV: Above target | **Table 2b.** Coverage of the 2026 Spring COVID-19 vaccination campaign in eligible population, counting those alive and resident in Wales as at 02/07/2026, by Local Health Board of residence.<br><br>Local Health Board of Residence / Eligible population (n) / Vaccinated (n) / Coverage (%) / Of those vaccinated, number with no previous doses (n)<br>Aneurin Bevan UHB 81,301 41,583 51.15 69<br>Betsi Cadwaladr UHB 107,815 54,830 50.86 175<br>Cardiff and Vale UHB 58,533 30,207 51.61 87<br>Cwm Taf Morgannwg UHB 59,237 29,695 50.13 48<br>Hywel Dda UHB 63,315 30,119 47.57 119<br>Powys THB 23,307 12,483 53.56 61<br>Swansea Bay UHB 52,014 26,830 51.58 47<br>All Wales 445,522 225,747 50.67 606<br><br>***Table 4.3.2*** *Uptake of influenza immunisation in Wales for the 2025/26 season in patients aged 65 years and older, by local health board, comparing patients in the most deprived and least deprived quintiles of areas*<br><br>Local Health Board / Denominator (n) / Numerator (n) / Uptake (%) / Uptake in most deprived areas (%) / Uptake in least deprived areas (%) / % Gap<br>Aneurin Bevan UHB 132,066 96,376 73.0 65.8 79.3 13.5<br>Betsi Cadwaladr UHB 175,152 129,086 73.7 66.3 78.7 12.4<br>Cardiff and Vale UHB 94,751 67,897 71.7 59.1 78.1 19.0<br>Cwm Taf Morgannwg UHB 96,611 70,072 72.5 68.1 78.3 10.2<br>Hywel Dda UHB 105,638 74,118 70.2 62.7 74.8 12.1<br>Powys THB 39,894 27,509 69.0 69.6 79.0 9.4<br>Swansea Bay UHB 86,970 59,312 68.2 61.3 73.8 12.5<br>All Wales 731,082 524,370 71.7 64.4 77.7 13.3<br><br>***Table 4.3.3*** *Uptake of influenza immunisation in Wales for the 2025/26 season in patients aged 16 to 64 years at clinical risk, by local health board, comparing patients in the most deprived and least deprived quintiles of areas*<br><br>Local Health Board / Denominator (n) / Numerator (n) / Uptake (%) / Uptake in most deprived areas (%) / Uptake in least deprived areas (%) / % Gap<br>Aneurin Bevan UHB 102,112 45,135 44.2 37.9 52.2 14.3<br>Betsi Cadwaladr UHB 110,831 47,319 42.7 35.4 48.2 12.8<br>Cardiff and Vale UHB 74,852 33,287 44.5 38.1 51.8 13.7<br>Cwm Taf Morgannwg UHB 74,966 33,745 45.0 41.5 50.2 8.7<br>Hywel Dda UHB 61,843 27,505 44.5 36.1 49.4 13.3<br>Powys THB 19,536 8,801 45.1 42.4 47.9 5.5<br>Swansea Bay UHB 59,550 21,859 36.7 33.1 42.7 9.6<br>All Wales 503,690 217,651 43.2 37.3 49.5 12.2<br><br>**Table 1.1.3 Uptake of RSV immunisation in those reaching their 75th birthday between 1st September 2024 and 31st August 2025 (first year routine cohort), by Local Authority of residence.**<br><br>Local Authority / Denominator / Vaccinated / Uptake (%)<br>Cardiff 2,618 1,755 67.0%<br>Vale of Glamorgan 1,347 944 70.1%<br>**Cardiff and Vale UHB** **3,965** **2,699** **68.1%**<br><br>Source: PHW VPDP |

| Priority | Performance Summary | Reported Period | On target? | Data |
|---|---|---|---|---|
| Health Protection | **Routine childhood immunisation**<br>• Up to date by age 4<br>  • For 1 January to 31 March 2026, **79.9%** of children are up to date with vaccination by age 4.<br>  • This is a decrease from the previous quarter (80.8%) and below the All-Wales average of 84.4%.<br>• Up to date by age 5<br>  • For 1 January to 31 March 2026, **85%** of children are up to date with vaccinations by age 5.<br>  • This is a decrease from the previous quarter (85.3%) and below the All-Wales average of 87.5%.<br>• HPV by age 15<br>  • For 1 January to 31 March 2026, uptake of HPV vaccine for children reaching 15 years of age was **75.6%**.<br>  • This is an increase on the previous quarter (74.9%)<br>  • This is below the All-Wales average of 76.2%. | Jan to Mar 2026 | Up to date by age 5: Below local and national target.<br><br>HPV by age 15: Below local and national target. |  <br>  <br>Source quarterly COVER data |

| Priority | Performance Summary | Reported Period | On target? | Data |
|---|---|---|---|---|
| Health Improvement | **Healthy weight:**<br>• 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.<br>• 42.1% of adults in Cardiff and Vale of Glamorgan are a healthy weight (aged 16-64), as compared to 35.9% of the Welsh average (National Survey for Wales (NSfW), 2024/25); 34.8% are eating five portions of fruit/vegetables a day, compared to 32.9% in Wales (NSfW, 2024/25) and 65.0% are meeting physical activity guidelines of being active for at least 150 minutes per week, as compared to 60.0% in Wales (NSfW 2024/25). There are no comparable data in other UK countries due to different methodologies being used.<br>• 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. | 2024/25 | **Healthy weight:**<br>Not meeting target |  |

| Priority | Performance Summary | Reported Period | On target? | Data |
|---|---|---|---|---|
| Health improvement | **Diabetes**<br>• **Inequity in the uptake**<br>  • Most recent data (Q1 26/27) shows reduction in gap between highest and lowest uptake rates at cluster level compared to baseline (18.7% gap, from 27.2% Dec 25). Q4 25/26 gap was 25.8%<br>• **Paediatric HbA1c**<br>  • The Health Board PDU has moved in a positive direction from 'alarm' status to 'alert' status in most recent NPDA report (2024-25 data)<br>• **Patients who have had foot surveillance and urine albumin recorded**<br>  • Slow but sustained improvement since January 2026 with regards urine albumin recorded; static/slight recent decrease in foot surveillance recorded | July 26 | Below target | Patients who have had foot surveillance/urine albumin recorded - see data tables<br><br>Gap between highest (54.7%)and lowest uptake rates (36.0%) of all 8 care processes at cluster level reduced. Whilst lowest uptake rate is increasing, there has been a drop in the highest uptake rate, only within this quarter. |

| Priority | Performance Summary | Reported Period | On target? | Data |
|---|---|---|---|---|
| Health Improvement | **Smoking**<br>• Percentage of the estimated smoking population of Cardiff and Vale who **made a quit attempt via smoking cessation services** ('treated smokers')<br>  • A total of 342 adult smokers made a quit attempt via smoking cessation services. This represents 0.88% of the annual 5% target (Q4 2025/26).<br>  • This number is a minor improvement to performance in Q3 and is above any quarter in the previous year (2024/25).<br>  • 2025/26 Q1to Q4 cumulative = 3.39%<br><br>• Percentage of Cardiff and Vale resident 'treated smokers' who were **CO-validated as successfully quitting at 4 weeks** post quit date<br>  • All smoking cessation services combined = 33%<br><br>*Note the latest data above is for Q4 2025/26 when the target for treated smokers was 5%. From Apr 2026 the target increased to 7.5%* | Q4 2025/26 (latest at June 26) | Below target<br><br>Below target |  <br>  |

## Smoking

*NHS Wales Performance Framework measures*

| No. | Performance Measure | Reported Period | Performance Standard | In Month Performance | Trend | | | |
|---|---|---|---|---|---|---|---|---|
| 1. | Percentage of adult smokers who make a quit attempt via smoking cessation services<br><br>*Quarter 4 2025/26*<br>• *239 HMQ Community (incl. telephone service)*<br>• *71 HMQ Community Pharmacy*<br>• *32 Hospital Smoking Cessation Service* | Q4 25/26 | Annual Target (2025/26) is 5% of 38,800 smokers n = **1940**<br><br>Quarterly target is 1.25% of 38,800 smokers n = **475** | 0.88% (Q4 25/26)<br>Below national target<br>Meets local target 0.8 | **Q1** | **Q2** | **Q3** | **Q4** |
| | | | | | 310 = 0.8% (Q1 25/26) | 318 = 0.82% (Q2 25/26) | 341= 0.88% (Q3 25/26) | 342= 0.88% (Q4 25/26) |
| 2. | Percentage of adult smokers who make a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks.<br><br>*Quarter 3 25/26*<br>• *42% HMQ Community (excluding HMQ telephone service)*<br>• *0% HMQ Telephone Service*<br>• *32% Level 3 Community Pharmacy*<br>• *50% Hospital Smoking Cessation Service* | Q4 25/26 | 40% | 33% (Q4 25/26)<br>Below target | **Q1** | **Q2** | **Q3** | **Q4** |
| | | | | | 38% (Q1 25/26) | 32% (Q2 25/26) | 32% (Q3 25/26) | 33% (Q4 25/26) |

# Substance misuse

## *NHS Wales Performance Framework measures*

| No. | Performance Measure | Reported Period | Performance Standard | In Month Performance | Trend | | | |
|---|---|---|---|---|---|---|---|---|
| 3. | Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs and alcohol)*<br><br>*This measure includes people who have been referred to **health board services, health board commissioned services** (CAVDAS – Cardiff and Vale Drug and Alcohol Service) and **Dyfodol** (for people in contact with the criminal justice service) who live in the Cardiff and Vale area. The measure may also include other services outside Cardiff and Vale, but where the client resides in Cardiff and Vale.* | Q4 2025/26 | 4 quarter improvement trend (2025/26)<br><br>80%<br>(2026/27) | Q4 80.36% | **Q1** | **Q2** | **Q3** | **Q4** |
| | | | | | 68.70% | 78.73% | 83.44% | 80.36% |

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

## *Other measures*

| No. | Performance Measure | Reported Period | Performance Standard | In Month Performance | Trend | | | |
|---|---|---|---|---|---|---|---|---|
| n/a | Percentage of people who have been referred to **health board and health board commissioned services** who have completed treatment for substance misuse (drugs or alcohol).<br><br>This measure includes health board and health board commissioned services (CAVDAS – Cardiff and Vale Drug and Alcohol Service). | Q4 2025/26 | See above | Q4 80.18% | **Q1** | **Q2** | **Q3** | **Q4** |
| | | | | | 80.47% | 75.50% | 88.44% | 80.18% |
| | Percentage of people who have been referred **to health board services** who have completed treatment for substance misuse (drugs or alcohol). | Q4 2025/26 | See above | Q4 93.55% | 95.52% | 87.76% | 87.14% | 93.55% |

## Immunisation and vaccination

*NHS Wales Performance Framework measures*

| No.v | Performance Measure | Reported Period | Performance Standard | In Month Performance | Trend | | | |
|---|---|---|---|---|---|---|---|---|
| 4. | Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose) | Jan – Mar 26 | 95% | 85% | **Jan-Mar** | **Apr-Jun** | **Jul-Sept** | **Oct-Dec** |
| | | | | | 85% | | | |
| 5. | Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15 | Jan - Mar 26 | 90% | 75.6% | **Jan-Mar** | **Apr-Jun** | **Jul-Sept** | **Oct-Dec** |
| | | | | | 75.6% | | | |
| 6. | Percentage uptake of the influenza vaccination amongst adults aged 65 years and over<br><br>*Applicable during: 01.09.2025 - 31.03.2026* | 1 Oct 25 – 31 Mar 26 | 75% | 71.7% | **01/10/25-31/03/26** | | | |
| | | | | | 71.7% | | | |
| 7. | Percentage uptake of the Respiratory Syncytial Virus (RSV) for those turning 75 years old (first year routine cohort) | Feb 26 | 70% | 59.7% | **Feb 26** | **Jun 26** | | |
| | | | | | 59.7% | 68.1% | | |

## Diabetes

*NHS Wales Performance Framework measure*

| No. | Performance Measure | Reported Period | Performance Standard | In Month Performance | Trend | | | |
|---|---|---|---|---|---|---|---|---|
| 9. | Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within last 15 months | June 26 | 80% | 68.32% | **March 26** | **April 26** | **May 26** | **June 26** |
| | | | | | 69.52% | 68.66% | 68.64% | 68.32% |
| 10. | Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within last 15 months | June 26 | 80% | 65.83% | **March 26** | **April 26** | **May 26** | **June 26** |
| | | | | | 64.68% | 64.73% | 65.21% | 65.83% |

# Cardiff and Vale UHB & Welsh Government  Escalation Board

Public Health updates June 2026

# Vaccination rates

***Exec lead: Claire Beynon***

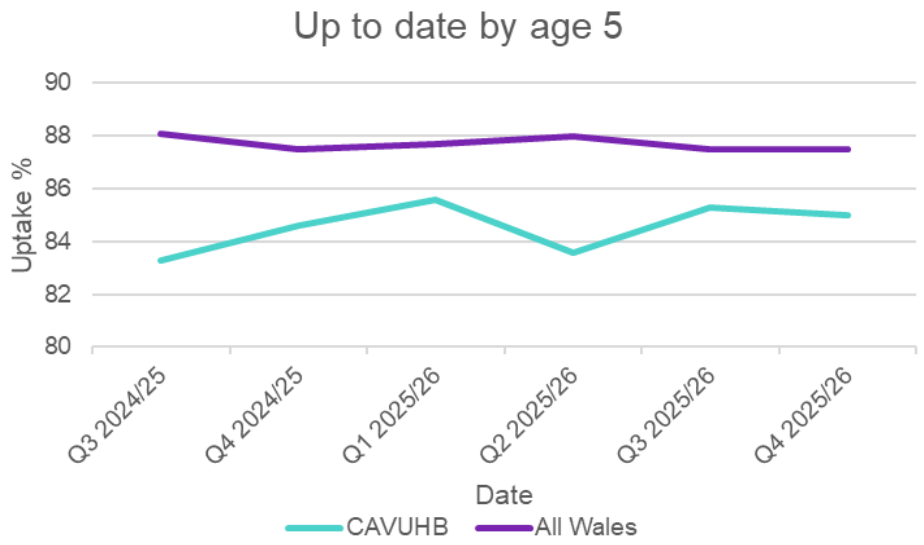
The UHB has three quantitative de-escalation criteria within the Population Health domain, two of which relate to vaccination rates (see below) - *our plan makes a commitment to meet the required standard for both of these in 26-27*

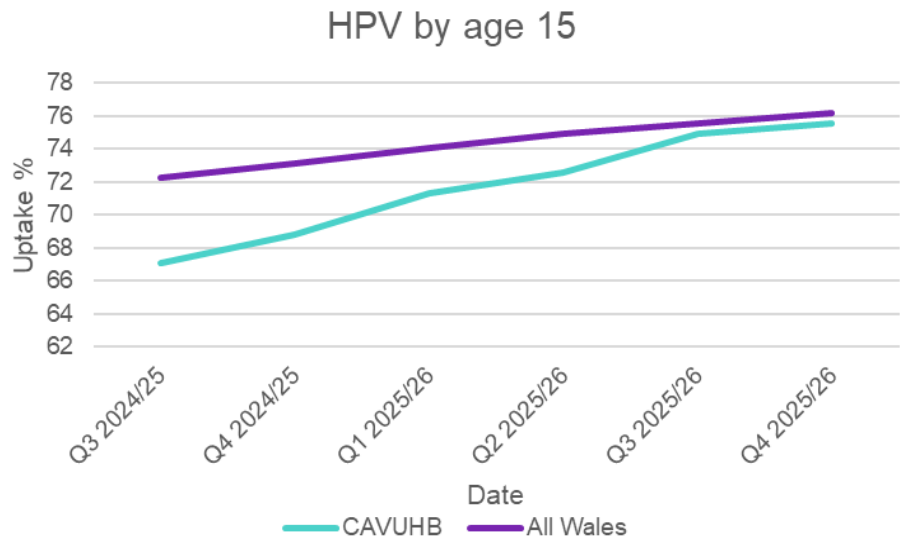
| Measure | De-escalation Requirement | | Q3 2024/5 | Q4 2024/5 | Q1 2025/6 | Q2 2025/26 | Q3 2025/26 | Q4 2025/26 | Q1 2026/27 |
|---|---|---|---|---|---|---|---|---|---|
| % of children up to date with scheduled vaccinations by age 5 to be in line with all Wales average | **Demonstrate progress over two consecutive quarters** | CAV data | 83.3 | 84.6 | 85.6 | 83.6 | 85.3 | 85.0 | |
| | | *All-Wales data* | 88.1 | 87.5 | 87.7 | 88.0 | 87.5 | 87.5 | |
| | | *Gap* | **4.8** | **2.9** | **2.1** | **4.4** | **2.2** | **2.5** | |
| Human Papillomavirus (HPV) vaccine uptake rate for children by the age of 15 to be in line with all Wales average | | CAV data | 67.1 | 68.8 | 71.3 | 72.6 | 74.9 | 75.6 | |
| | | *All-Wales data* | 72.3 | 73.1 | 74.1 | 74.9 | 75.6 | 76.2 | |
| | | *Gap* | **5.2** | **4.3** | **2.8** | **2.3** | **0.7** | **0.6** | |

**KEY**

Green- progress in closing gap to Wales average (baseline Q3 24/25)

Amber- widening gap to Wales average (baseline Q3 24/25)

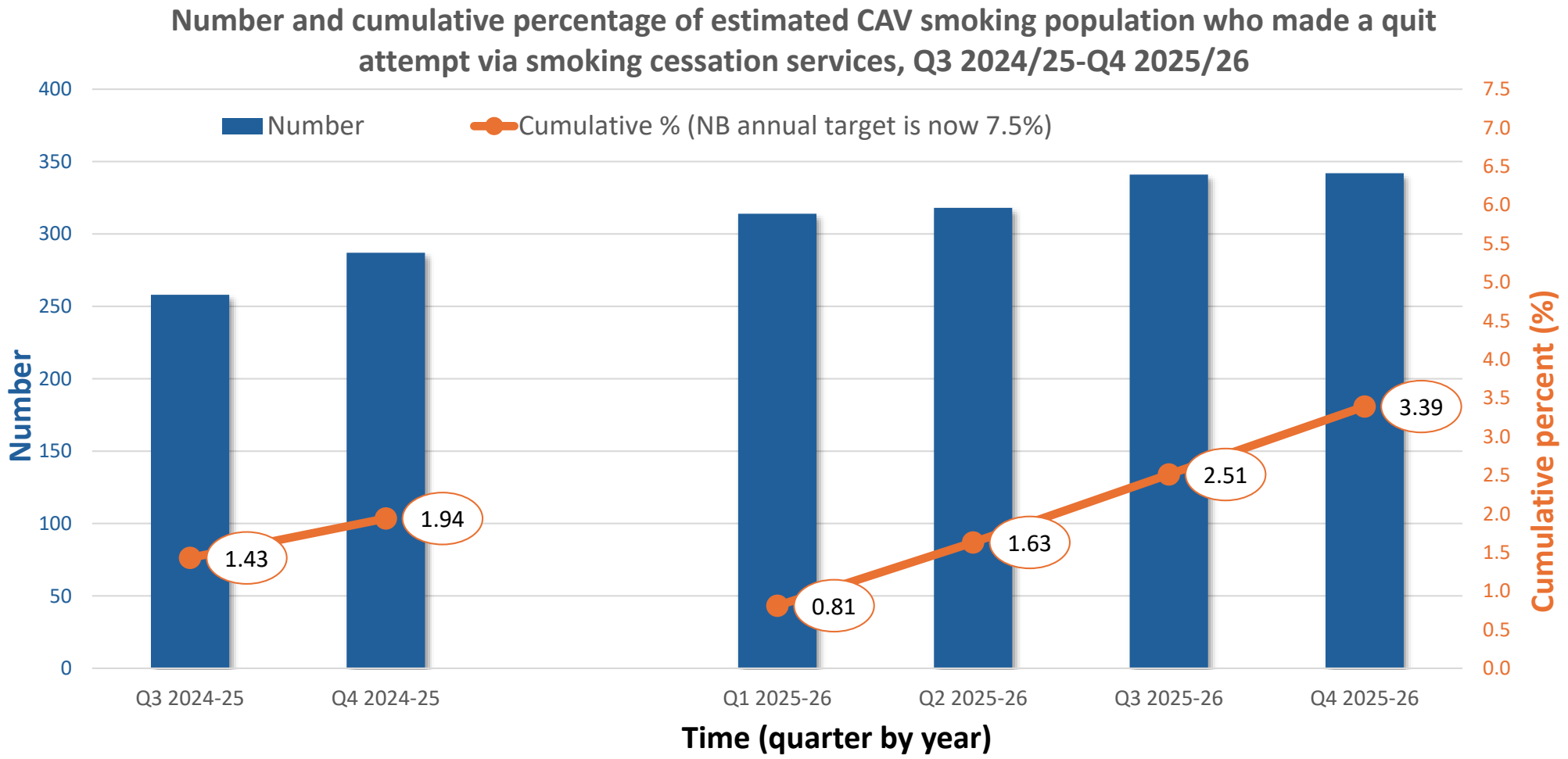


# Smoking cessation

***Exec lead: Claire Beynon***

Percentage of adult smokers who make a quit attempt via smoking cessation services towards the target compliance over the 12-month period measure *– criterion met.*



| | | | | | |
|---|---|---|---|---|---|
| Report Title: | No-smoking and Smoke-Free Environment Policy compliance at Cardiff & Vale hospital sites | | Agenda Item No: | | 5.2 |
| Meeting: | Quality Committee | Public | X | Meeting Date: | 28/07/2026 |
| | | Private | | | |
| Lead Executive Title: | Executive Director of Public Health | | | | |
| Report Author/s Title: | Consultant in Public Health | | | | |

Report Focus Summary – **AAA Framework:**

**ALERT** *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

**ADVISE** *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

Smoking is a lead cause of preventable morbidity, mortality and inequalities which costs the Cardiff & Vale health and care system ~£100m each year.

The Quality Committee previously endorsed a phased approach to enhance compliance with the Health Board's No-Smoking and Smoke-free Environment policy. The six-month 'educational' phase has now concluded, and a review report has been received from local authority partners summarising activity, progress and opportunities for ongoing improvement.

The Health Board is not currently ready to transition to 'full enforcement'. An ongoing cross-organisation commitment, and actions to address recommendations, are required to maintain momentum with this work and ensure progress is made to improve smoke-free policy compliance on Health Board grounds.

**ASSURE** *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

**Board/Committee Response Required** ***(please select only one)***
*To confirm the action Members are being asked to take considering the AAA Framework*

| **Assurance** | | **Approval** | | **Information/Noting** | X |
|---|---|---|---|---|---|

**Recommendations**
*Recommendations should be clear, actionable, and aligned to the AAA summary above.*

The Quality Committee is asked to:

- Note the contents of this paper and the accompanying six-month review report.
- Support the commitment for a Health Board-wide group to continue to drive this work forward, and receive an update on progress at six months.

**Governance Route** ***(please list other Committee/Groups this report has been to)***

| | |
|---|---|
| ***Where** it's been:* | *No other groups* |
| ***When** it went:* | *N/A* |
| ***What** decision was made:* | *N/A* |

**Main Report**
*Background & Current Situation*

In September 2025, the Quality Committee endorsed a phased approach to assess and enhance compliance with the Health Board's No-Smoking and Smoke-free Environment policy. The initial phase of this work involved a six-month 'educational' phase, and if successful, to be followed by a 'full enforcement' phase. The Health Board partnered with the local authorities locally, as the statutory organisation responsible for enforcing the law, to

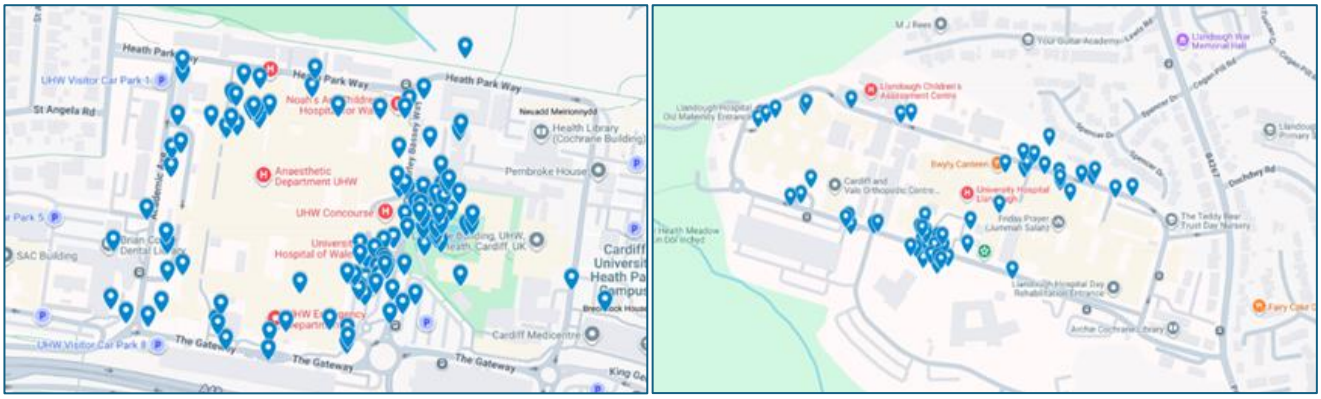
progress the work. This paper updates Quality Committee on learning from the six month 'educational' phase.

A key strand of this work involved introducing no-smoking patrols, carried out by an enforcement officer, at all five hospital sites across Cardiff and Vale of Glamorgan. (Shared Regulatory Services, (SRS) contracted an external enforcement agency to deliver this service on their behalf.

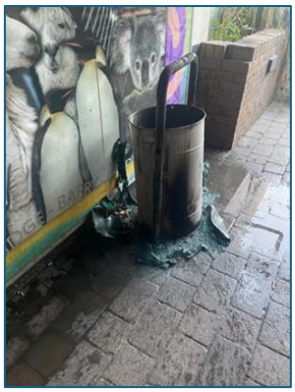
Through these patrols, 1,380 interactions with people smoking on hospital sites were recorded between mid-November 2025 and mid-May 2026. The breakdown by patients, visitors, staff, students and contractors, and site, is as follows:

| Hospital site | Staff | Visitor | In-patient | Out-patient | Contractor | Student | Total |
|---|---|---|---|---|---|---|---|
| **UHW** | 100 | 468 | 209 | 139 | 12 | 6 | **934** |
| **UHL** | 50 | 83 | 187 | 27 | 2 | 1 | **350** |
| **Barry** | 5 | 14 | 0 | 13 | 0 | 1 | **33** |
| **CRI** | 1 | 15 | 1 | 28 | 1 | 0 | **46** |
| **St David's** | 0 | 7 | 0 | 7 | 2 | 1 | **17** |
| **TOTAL** | **156** | **587** | **397** | **214** | **17** | **9** | **1380** |

Robust intelligence of smoking 'hotspot' locations was also generated, as shown in the example geo-tagged interaction maps below for UHW (left) and UHL (right):




As a cause of complaints and because of fire safety risks, evidence of discarded cigarette waste and other smoking-related litter on our sites was also collected (below):



The data collected confirm a disappointing position with regards both internal policy compliance and overall compliance with the law. However, The interactions have presented many new opportunities to raise awareness of smoking harms, encourage policy/legislation compliance to protect health, and signpost people to expert stop smoking services. In addition, broader benefits include reduced smoking-related harm to other hospital site users, and adverse environmental impacts (litter/waste and fire risk).

The 'educational' phase was designed to collect data and learning with a view to transition to 'full enforcement' after the learning from the educational phase was gleaned. However, this isn't possible at present due to two main developments:

i. SRS notified the Health Board that the contract with the external service provider who deliver smoking patrols at hospital sites had been terminated. As a result, patrols ceased on 08/07/2026. This was a unilateral decision by SRS, influenced by concerns about both service quality and rising costs from the external contractor (currently ~£9k/month).

ii. SRS's 'educational' phase review report stated that, in their professional opinion as an enforcement authority, the Health Board still has some way to go to ensure internal procedures are sufficiently robust to support a formal move to full enforcement. Their report (Appendix 1) made recommendations in relation to key areas for improvement, notably: staff non-compliance management procedure, nicotine dependence management patient pathway, mental health patients smoking at University Hospital Llandough and communications.

On the first point above alternative options have been explored with waste/neighbourhood services at both Cardiff and Vale of Glamorgan Councils. Discussions have focused on maintaining momentum with education and signposting, specifically considering whether there are opportunities to incorporate this activity into routine litter enforcement patrols which could extend to include hospital sites. This is reliant on the local authorities seeing this as a priority.

On the second point there is clearly more work for the Health Board to do across several key areas. The internal 'Enforcement of No-Smoking on Hospital Sites Task and Finish Group' – comprising representation from across the Health Board – is committed to progressing a suite of actions to address the recommendations outlined in the SRS report. Each group member must commit to progress actions for which they (or their service/team) are responsible; a Health Board-wide commitment is important to help support this work and encourage colleagues to prioritise action.

The Committee is asked to support the commitment for a Health Board-wide group to continue to drive this work forward and act on the recommendations in the report over the next six months, including seeking environmental modification, developing staff non-compliance management procedure and working with legislators to find options for the in-patient group. A further paper to be brought forward at six months to update on progress on the Health Board's internal necessary actions.

This work has raised interest amongst system partners on the implementation of smoke-free place legislation in Wales. As the only Health Board and local authority partnership to have worked towards full enforcement of smoke-free places, there is learning to share with other Health Boards, local authorities across the UK and the Welsh Government.

**Appendices:**

- Appendix 1: 'Review of the six-month educational phase of Smoking Enforcement in Hospital Grounds' Smoking Enforcement in Hospital Grounds' Shared Regulatory Services

**Strategic Alignment – Shaping Our Future Wellbeing:**

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

**Impact Assessment**

**Risk**: No

N/A

**Safety**: Yes

As well as being a health risk, smoking on hospital sites increases the risk of fires, putting staff, patients and visitors at risk. Actions are being taken to ensure all site users are aware of the legislation and the risks associated with non-compliance. This requires action across the organisation.

**Financial**: Yes

The work is currently being funded by the Public Health team using an external grant. The amount that SRS want to continue this work is not sustainable, therefore a range of alternative options are being explored.

**Workforce**: Yes

The workforce is asked to support no smoking on hospital sites. Some staff are being asked to undertake additional tasks to facilitate this. These are within the scope of their existing roles.

**Legal**: No

Legal implications as consequence of enforcement of no smoking legislation on hospital sites will be handled by Shared Regulatory Services.

**Reputational**: Yes

There is a reputational risk to the Health Board if it does not take action against smoking which is the biggest cause of preventable mortality and morbidity. Previously there were several complaints about smoking on site each month, these have reduced in recent months.

**Socio Economic**: Yes - *https://www.gov.wales/socio-economic-duty-guidance*

Most smoking related deaths occur in deprived communities. People who smoke have a greater need for health services than non-smokers, and therefore more frequently attend hospitals. Ensuring that smoking does not happen on hospital sites will ensure that non-smoking is seen as the norm, resulting in better quality of life for individuals, and freeing up resources. These benefits will be particularly felt by those living in areas of deprivation.

**Equality & Health**: No

N/A

**Decarbonisation**: No

N/A

**Welsh Language**: No

All public facing information is bilingual, the Help Me Quit service offers support to people wishing to quit smoking can be provided in Welsh.

# Cardiology Review:  Improvement Plan

**Version History:**

| | |
|---|---|
| Date: | 20th May 2026 |
| Author: | Cardiology Project Team |
| Project Exec / SRO: | Paul Bostock |
| Version No: | 1.3 |
| Status: | Issued |

## Cardiology Executive Summary

The Cardiology Review Project has been established to address longstanding challenges in the delivery of consistently high-quality care within the Cardiology service. Central to the identified problem is unwarranted variability in care quality alongside a working environment that has not consistently enabled staff to feel supported, valued, and professionally safe. These factors have contributed to service instability and risk to sustainability. In response, the programme has set an ambitious but necessary aim: by September 2028, to establish a psychologically safe, cohesive, and empowered Cardiology team culture, enabling the consistent delivery of high-quality, patient centred care across all Cardiology services.

Significant progress has already been made in laying the foundations for sustainable improvement. Early programme activity has focused on team engagement and cultural reset, including structured engagement sessions, regular leadership walkabouts, and ongoing meetings with departmental leads. A clear improvement methodology has been agreed, supported by the development of a driver diagram, defined workstreams, and strengthened governance and reporting arrangements. Office 365 tools have been embedded to improve programme visibility, communication, and prioritisation.

Alongside this foundational work, a number of tangible service and quality improvements have been progressed:

- **Education and workforce assurance:** Enhanced monitoring by the GMC relating to the trainee programme for resident doctors has been successfully stepped down, reflecting improved oversight, support, and educational environment.
- **Quality Management System (QMS):** Further work is progressing to align Cardiology services into the Health Board's QMS programme,
- **Appointment of professional and clinical leads:** strengthening accountability for quality, safety, and standards.
- **Clinical and operational resilience:** Successful recruitment of a locum Electrophysiologist and two locum Interventional Cardiologists has significantly strengthened clinical capacity, supporting safer patient care and improved ability to meet commissioned service requirements.
- **Workforce and operating model development:** Job planning is progressing with an agreed programme of work, and a review of roles, responsibilities, and the future operating model for the Directorate Management Team (DMT) is underway to enable clearer accountability and more effective leadership.

Collectively, these improvements demonstrate early momentum and a clear shift towards stronger governance, safer systems, and a more supportive and professionally accountable working environment.

## Removal of GMC/HEIW enhanced monitoring

In May 2024, Health Education and Improvement Wales (HEIW) undertook a review of the cardiology training environment within Cardiff and Vale University Health Board following adverse trainee feedback relating to training opportunities, culture, and behaviours. As a result, the department was placed under enhanced monitoring in July 2024, with a defined set of requirements and recommendations forming the Cardiology Action Plan.

A follow-up visit in January 2025 confirmed continued progress, with the HEIW panel noting meaningful improvements in team structure, consultant leadership, and departmental culture. The panel recognised that changes led by the consultant body, supported by senior registrars, had strengthened team cohesion and created a more supportive learning environment. Reflecting this progress, the department's GMC risk rating improved from 12 (high) to 8 (moderate).

Despite this progress, ongoing concerns remained regarding training opportunities in electrophysiology and devices, access to cardiac CT and outpatient clinics, departmental induction, and the educational needs of lower grade trainees. Enhanced monitoring therefore remained in place throughout 2025.

Building on the feedback from the January 2025 visit, additional improvement work was undertaken. Further 6-monthly HEIW reviews were undertaken and in February 2026 enhanced monitoring status was lifted. This represents a significant achievement for the department and provides clear evidence of sustained improvement in leadership, governance, culture, and educational delivery. The decision reflects strong assurance that actions have been embedded, the training environment stabilised, and a positive, supportive culture established. It also demonstrates the department's ongoing commitment to continuous improvement, responsiveness to external scrutiny, and the delivery of high-quality training and patient care.

**Key Actions Delivered**:

- Strengthened trainee feedback mechanisms
- Reinforced a safe and transparent speaking up culture
- Established regular trainee forums
- Improved departmental induction
- Enhanced consultant leadership and team structure
- Improved access to training opportunities
- Strengthened departmental culture -Improved cohesion between consultants, registrars, and resident doctors.

**Physiology Update:**

## What has been delivered

- **Scan for Safety**: Phase 1 implementation – basic stock scanning and patient assignment training completed and now live; phase 2 (enhanced stock control and wastage reduction) planned for W/C 11 May 2026
- **Workforce capacity**: Band 7-8 staff have completed VBA training, with VBA process now actively underway and embedded within routine practice.
- **Quality & Safety:** Dedicated protected time for training and communication established within routine quality & safety session.
- **Performance oversight**: Development of a KPI dashboard has been initiated, to support oversight of mandatory training, VBAs and workforce absence.
- **Culture & leadership**: Team development session schedule for May Q&S, including civility saves lives and staff charter input and speaking up safely awareness.
- **Change delivery:** Shaping change workstreams agreed and leads identified; meetings to commence implementation phase.
- **Digital enablement:** Implementation of Fysicon data management system for the device service initiated.

## Challenges & Risks

- **Clinical and Administrative Workforce Constraints** Ongoing workforce limitations across clinical and administrative teams are impacting operational performance and delivery. This continues to contribute to service pressures and sustained backlog growth.
- **Scan for Safety Programme Delivery and Embedding** Delays in the full implementation and embedding of Scan for safety deliverables are affecting service delivery. This presents potential risks to clinical team capacity and patient safety. Hardware-related issues are also contributing to delays.
- **Fysicon Implementation** Progress of Fysicon has been hindered by implementation of VPN link between the UHW and Fysicon, requiring support from DHCW.
- **Patient Safety and Capacity Risks** Significant delays in monitoring reviews, increasing unmet demand, data quality concerns, and capacity constraints are collectively elevating patient safety risks and constraining timely intervention. Escalated through Executive Reviews and Quality Meetings with a scheduled presentation at Quality Committee in June.

## Next Steps

- Targeted recruitment is underway, with roles out to advert for short-term locum and bank administrative support to provide immediate capacity and stabilise service delivery. This will be complemented by a comprehensive workforce review to be undertaken by the new lead once in post, to identify sustainable staffing solutions and longer-term service resilience
- Implement Scan for Safety – Phase 2 (w/c 11 May 2026), focusing on enhanced stock control process and reduction in device wastage. Further work is needed to strengthening governance, training, and performance monitoring to ensure consistent adoption, embed processes in practice.
- Progress development of the KPI dashboard
- Continue delivery and monitoring of VBAs, ensuring outputs are actioned and tracked.
- Initiate Shaping change workstreams, with leads convening meeting to agree priorities, milestones and measure of success.
- Team engagement: Weekly device service “breakfast meeting” to be established for routine update, training and communication.
- Weekly operational/working group meetings are in place to agree and oversee implementation of actions to address monitoring delays, short- & long-term workforce solutions and improve systems and processes to de-risk patient safety concerns. The implementation of Fysicon will also support addressing data quality concerns.

## Cardiology Dashboard

A high-level comparison of February 2025 and February 2026 identified measurable improvements across several key workforce performance indicators. This reflects strong engagement and demonstrable progress in addressing several agreed recommendations. To sustain momentum and support ongoing oversight, a dashboard is being developed to provide real-time data. This will be routinely reviewed and monitored through the Directorate Management Team (DMT) forum.

.

| MWAG Job Plan | Feb-25 | | | Feb-26 | | |
|---|---|---|---|---|---|---|
| | Headcount | % signed off | % Compliance | Headcount | % signed off | % Compliance |
| **Cardiac Services** | **27** | **48.15%** | **3.70%** | **31** | **58.06%** | **19.35%** |
| Cardiology Medical | 17 | 58.82% | 5.88% | 21 | 66.67% | 23.81% |
| Cardiothoracic | 10 | 30.00% | 0.00% | 10 | 40.00% | 10.00% |

Clear improvements identified. A structured programme of work has been developed to support delivery. This programme will prioritise Cardiac Surgery and Thoracic services throughout Quarter 1 of 2026.

| VBA% by Staff Group | | Feb-25 | Feb-26 |
|---|---|---|---|
| | Additional Clinical Services | 62.07% | 83.58% |
| | Administrative and Clerical | 42.50% | 73.68% |
| | Healthcare Scientists | 61.54% | 54.17% |
| | Nursing and Midwifery Registered | 77.22% | 72.03% |
| **Cardiac Services Total** | | **69.95%** | **71.98%** |
| B1 Cardiology | | 52.38% | 61.70% |
| Cardiac Surgery Medical | | 75.00% | 100.00% |
| Cardiology Outpatients | | 72.73% | 90.00% |
| Catheter Room | | 68.97% | 90.32% |

Overall VBA performance within Cardiac Services improved, increasing from 69.95% to 71.98%. Significant improvements were observed within Additional Clinical Services and Administrative and Clerical staff groups, rising from 62.07% to 83.58% and from 42.50% to 73.68% respectively. Equally, strong gains were identified across several sub specialities, such as Ward B1, Cardiac Surgery, Catheter Room and Cardiology Outpatients.

This analysis has provided clear insight into areas requiring further improvement and targeted intervention. Ongoing work is focused on these key areas to develop a structured improvement plan and strengthen overall compliance.

| Mandatory Training<br>Staff Group | Feb-25<br>% Compliance | Feb-26<br>% Compliance |
|---|---|---|
| Additional Clinical Services | 77.94% | 77.34% |
| Administrative and Clerical | 74.31% | 78.57% |
| Healthcare Scientists | 74.48% | 69.52% |
| Medical and Dental | 21.44% | 40.67% |
| Nursing and Midwifery Registered | 83.85% | 85.03% |
| | 75.66% | 77.62% |

Overall compliance improved from 75.66% to 77.62. Improvements were observed across Administrative and Clerical, Medical and Dental, and Nursing and Midwifery Registered staff groups, with the most notable improvement seen within Medical and Dental, where compliance increased from 21.44% to 40.67%. These findings highlight continued progress overall, alongside specific areas requiring targeted focus to sustain and further improve compliance.

| Department | Sum of Leavers FTE | Feb -25 Sum of WTE % Turnover | Sum of Leavers FTE | Feb -26 Sum of WTE % Turnover |
|---|---|---|---|---|
| Adult Cardiac ITU | 5.00 | 7.30% | 2.96 | 4.41% |
| B1 Cardiology | 1.00 | 2.27% | 1.60 | 3.52% |
| C3 North / CCU | 2.51 | 4.78% | 0.72 | 1.45% |
| Cardiac Directorate Support | 1.00 | 10.69% | 0.00 | 0.00% |
| Cardiac Physiology | 14.75 | 26.50% | 8.00 | 13.77% |
| Cardiac Rehabilitation | 0.00 | 0.00% | 0.40 | 6.64% |
| Cardiac Services CNS & NP | 1.00 | 2.51% | 1.64 | 4.03% |
| Cardiac Surgery Medical | 2.00 | 12.56% | 0.64 | 4.72% |
| Cardiology Medical | 3.00 | 9.40% | 1.60 | 4.96% |
| Cardiothoracic Ward | 4.48 | 10.58% | 2.60 | 5.73% |
| Catheter Room | 3.76 | 11.93% | 2.00 | 6.67% |
| Perfusion | 0.00 | 0.00% | 0.00 | 0.00% |
| **Total** | **38.49** | **9.17%** | **23.16** | **5.47%** |

Overall turnover within Cardiac Services reduced significantly, with total leavers decreasing from 38.49 FTE (9.17% turnover) to 23.16 FTE (5.47%). With improvements were evident across the majority of departments.

Cardiac Physiology, while remaining the area with the highest turnover, showed a marked improvement, reducing from 26.50% to 13.77%. Overall, the data indicates improved workforce stability across Cardiac Services, with a small number of targeted areas requiring continued monitoring.

## Recommendations Summary

The directorate has moved from recovery to stabilisation, now operating with improved governance, clearer leadership, stronger safety culture, and more consistent workforce processes. The next phase focuses on:

- Embedding cultural change (engagement charter, behavioural frameworks).
- Completing demand and capacity modelling to inform sustainable service design.
- Implementing a formal Quality Management System.
- Advancing service redesign in outpatients, Cath labs, and subspecialist areas.

With these foundations in place, the directorate is positioned to achieve the long-term aim of a psychologically safe, cohesive, high-performing cardiology service.

Summary Table:

| Status | No. Recommendations |
|---|---|
| In Progress | 32 |
| Completed | 30 |
| Not Started | 6 |
| De-Scoped | 3 |

## Recommendation Updates

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 1 | Act on concerns about individuals not aligning with organisational values via appropriate policies. | Throughout the review, the team have identified a small number of individuals who have worked outside the values and behaviours of the organisation. Whilst these individuals will not be individually referred to within the report, an addendum report has been supplied, that outlines the concerning themes and recommendations for action under the appropriate Policies & Procedures. These need to be acted upon. | To address and act upon behavioural concerns identified during the organisational review, ensuring alignment with the organisation's values and behaviours through appropriate policy-driven actions. | Key behavioural concerns have been identified.<br>Organisational values and policies are reinforced.<br>Step are taken to improve accountability. | Thursday, December 31, 2026 | Ongoing process. | In Progress |
| 2.1 | Introduce hot and structured debriefs (e.g. MedTRIM) after challenging clinical events. | The Cardiology Directorate should implement hot debriefs as well as structured debriefs, such as MedTRIM to support improved management, communication, learning and support for teams and individuals following challenging clinical situations. | Strengthen team communication, enhance learning from challenging clinical events, and improve emotional and professional support for staff. | Improved consistency and quality of post-event learning and reflection.<br>Enhanced team communication and shared understanding following critical incidents.<br>Better emotional wellbeing and support for staff involved in challenging situations. | Tuesday, September 29, 2026 | A lead has been identified, with a start date expected within the next 2 - 3 months. A Focus Group will be established once the lead is in post. In the meantime, insight and learning from other areas on structured debrief processes is being gathered, with the aim for the Focus Group to review and tailor an approach for Cardiology. A full implementation plan, will also be developed as part of this focus group. | In Progress |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 2.2 | Provide Civility Saves Lives training across all cardiology staff groups. | The directorate should implement specific training on Civility Saves Lives across all professional groups within in cardiology. | Promote a consistently respectful, supportive, and high-performing team culture within the Cardiology Directorate. | Improved understanding of the impact of behaviours on team performance and patient safety.<br>Increased confidence among staff to address incivility constructively. Strengthened culture of respect, collaboration, and psychological safety.<br>Reduction in incidents linked to poor communication or unprofessional behaviours. | Sunday, June 28, 2026 | A Task and Finish Group, chaired by people and Culture has been established; with representatives from all disciplines and Trade Union. The aim of the group is to develop a detailed roll out plan, tailoring the approach to each staff group.<br><br>Planned sessions to date: -<br>18th May 2026<br>GMC session on Professionalism, including Civility Saves Lives to be held for cardiology consultant team.<br>7th May 2026<br>GMC session on Professionalism, including Civility Saves Lives held for cardiac surgery team including surgeons, anaesthetists, scrub team, ODP, perfusion team & trainees. | **In Progress** |
| 2.3 | Launch simulation training covering technical and non-technical skills, with anaesthetics collaboration. | The directorate should introduce a programme of simulation training with a focus both technical and non-technical skills including human factors and crew-resource management. This should be done in collaboration with the department of anaesthetics. Consideration should be given to external facilitation. | Enhanced clinical performance, teamwork, and patient safety. | Improved technical competence and confidence in managing complex clinical scenarios. Strengthened non-technical skills, including human factors awareness and crew-resource management. | Tuesday, September 29, 2026 | Early planning is underway. Lead and key stakeholders have been confirmed, and a focus group is now being formed to shape the implementation plan. | **Not Started** |
| 2.4 | Reinforce mandatory WHO checklist use in Cath labs and audit compliance. | The review team recommends that the mandatory use of a WHO checklist is reinforced as standard practice for the Cath labs moving forward and that compliance is audited and monitored. | | | Thursday, December 31, 2026 | This recommendation is aligned to the work that is taking place with the WHO collaborative. | **In Progress** |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 3 | Conduct demand and capacity review for secondary and tertiary cardiology work. | A specific demand and capacity piece of work considering secondary and tertiary work should be undertaken. So that clarity of expectation can be established regarding work expected of all cardiologists. | Clear and equitable expectations for all cardiologists by completing a comprehensive demand-and-capacity review of secondary and tertiary work. | A clear understanding of the demand placed on cardiology services and the capacity required to meet it.<br>Transparent expectations for cardiologists regarding their secondary and tertiary workload.<br>Evidence-based workforce and service planning to support sustainable, equitable distribution of work. | Monday, September 28, 2026 | Update to job-plans underway for all consultants in service, to accurately assess workforce DCC capacity.<br><br>Specific pieces of demand/capacity work ongoing within cardiology, including<br>- Implanted Devices<br>- GP referral triage<br>- eAdvice<br>- PCI & TAVI activity levels<br>- Interventional cardiology workforce.<br><br>. | In Progress |
| 4 | Promote Speaking Up Safely within cardiology. | The review team recommends raising awareness and promoting the use of Speaking Up Safely within Cardiology | To increase awareness and encourage routine use of the Speaking Up Safely process across the Cardiology Directorate. | Improved staff confidence in raising concerns promptly and appropriately. Greater visibility and uptake of the Speaking Up Safely pathway. Enhanced culture of openness, psychological safety, and early problem-identification. | Sunday, June 28, 2026 | Trade unions are holding Speaking up safely sessions. Sessions are planned in May with the GMC and NMC which is part of the formal response. Speaking up safely awareness and promotion will also be discussed and progressed as part of the Civility saves lives Task & Finish Group. | In Progress |
| 5 | Establish a weekly senior clinical meeting to review cardiology business and concerns. | There should be a multidisciplinary senior Clinical meeting supported by the management team which reviews on a weekly basis the business in Cardiology alongside any specific concerns. This meeting should be compulsory and recognised within everybody's working week as a time commitment | Consistent senior clinical oversight and effective management of Cardiology services. | reliable weekly forum is in place for senior clinicians and management to review service activity, issues, and concerns. Improved communication, coordination, and decision-making across the multidisciplinary team. | Tuesday, May 27, 2025 | The weekly meetings are now taking place as planned: the Friday Consultant Meeting and the Monday DMT meeting. Both are attended by MDT representatives from all professional groups | Completed (Done) |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 6 | Provide training for handling challenging conversations. | It is recommended that training for managing challenging conversations is put in place for the cardiology team. | Effective capability and confidence in handling challenging conversations. | Increased staff confidence and skill in handling difficult or sensitive conversations. Improved team communication, reducing escalation and unnecessary conflict. Enhanced psychological safety and a more supportive working environment. More consistent, professional approaches to addressing concerns or performance issues. | Sunday, June 28, 2026 | Sessions planned in May 2026 with the GMC and NMC, which is part of the formal response and include training in how to manage difficult conversations. | In Progress |
| 7 | Collaborate with People and Culture team to ensure consistent policy implementation. | It is also recommended that the Cardiology Directorate engage the People and Culture team to review implementation of policies to ensure consistency. | Strengthen the implementation of HR and organisational policies within the Cardiology Directorate, ensuring consistent and fair application. | Greater consistency in how policies are understood, applied, and monitored across Cardiology. Improved confidence among staff and managers in using People and Culture processes. Enhanced fairness, transparency, and trust in decision-making. | Thursday, May 28, 2026 | Training dates are being confirmed, and all staff requiring training will be booked onto the appropriate sessions. The DMT will oversee ongoing review and communication of these dates. A monthly dialogue between Leaders and the People & Culture team is recommended for reinstatement, and a date is needed to establish a recurring monthly drop-in session. | In Progress |
| 8 | Co-produce a unified cardiology vision across all subspecialties and professions. | The review team recommends that there is a co-produced Cardiology vision developed considering all parts and professions of Cardiology in order to draw together the individual subspecialist requirements. | A unified Cardiology vision that reflects the needs, priorities, and aspirations of all subspecialties and professional groups across the Directorate. | A shared, clearly articulated vision that aligns all areas of Cardiology around common goals. | Friday, October 30, 2026 | This is a long-term piece of work and needs to be scoped out and timescales agreed. Link to the charter development. | Not Started |
| 9 | Hold regular senior physiology team meetings with clinical governance focus. | The review team recommends that there is a regular senior team meeting in physiology that encompasses appropriate clinical governance. This should be compulsory for all of the senior team. | Strengthen clinical governance and leadership within Physiology. | A consistent forum is in place for senior physiology staff to review clinical governance, service issues, and priorities. Improved communication, shared decision-making. | Tuesday, September 23, 2025 | March 2026: This has been completed. | Completed (Done) |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 10 | Undertake organisational development work on team dynamics and behaviour. | The review team recommends that there is a specific piece of work on organisational development of team dynamics and behaviour. | Strengthened team dynamics, behaviours, and collaborative working across the Cardiology Directorate. | Improved interpersonal behaviours and more effective multidisciplinary team working.<br>Enhanced psychological safety, communication, and trust within and between teams.<br>A more cohesive, supportive, and high-performing culture across Cardiology. | Sunday, June 28, 2026 | This will be covered in the outputs from recommendation 4 Civility Saves lives. | In Progress |
| 10.1 | Develop an engagement charter with cardiology teams. | Consideration should be given to the development of an engagement charter, co-produced with teams within cardiology. | An Engagement Charter that sets out shared expectations, behaviours, and principles for positive engagement and collaborative working. | A clear, shared framework for how teams engage, communicate, and work together.<br>Stronger sense of collective ownership and mutual accountability.<br>More consistent, inclusive, and transparent engagement across the Directorate. | | This is a long-term piece of work and needs to be scoped out and timescales agreed - Pre cursor to this work is recommendation: 2.2, 4, 6, 10. | Not Started |
| 11.1 | Review and clarify attendance expectations for all cardiology meetings. | The cardiology directorate should review the current programme of regular directorate and clinical meetings and specify expected attendance across staff groups. This needs to include Quality and Safety, Mortality and Morbidity meetings in addition to other directorate meetings and should be benchmarked against other directorates within the Clinical Board and organisation. | Ensure effective governance and consistent engagement across the Cardiology Directorate. | A clear, structured meeting programmes.<br>Defined attendance expectations for each staff group to support consistent participation. Improved governance, communication, and decision-making across the directorate. | Thursday, February 12, 2026 | Feb 2026: This work has been completed, and the following meetings are now in place:<br>Quality & Safety Meeting<br>Mortality & Morbidity Meeting<br>Interventional MDT Meeting.<br><br>In addition, there is a Faculty of Educational Governance (FEG) structure in place. A FEG has been established for Cardiology, Cardiothoracic Surgery, and the Cardiac Surgery MDT Working Group.<br>The Quality & Safety, Mortality & Morbidity, and Interventional MDT meetings have been operating since February 2025, and the FEG and associated working groups were established in Q1 2026. | Completed (Done) |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 11.2 | Create standardised meeting etiquette for all professional groups. | There need to be a standardised etiquette for meetings that is shared and understood amongst all professional groups. | Adherence to a standardised etiquette for meetings that is shared and understood amongst all professional groups. | | Tuesday, May 26, 2026 | SOP developed and circulated with DMT for comments and formal approval. It was formally signed off at the DMT meeting on the 20th of April and subsequently disseminated across the directorate, including publication on the relevant SharePoint pages. | Completed (Done) |
| 12 | Conduct monthly walkarounds by directorate and board management to improve visibility. | It is recommended that there are structured regular (at least monthly) walk arounds by the directorate and clinical board management team to increase visibility and communication. | It is recommended that there are structured regular (at least monthly) walk arounds by the directorate and clinical board management team to increase visibility and communication. | Visibility, accessibility, and communication across Cardiology through structured, regular walkarounds involving the Directorate and Clinical Board management team. | Monday, December 8, 2025 | Feb 2026: A weekly walkaround takes place every Tuesday at 2:30pm. The venue rotates to ensure coverage of the full Directorate footprint. Clinical Board members also participate in walkarounds, either alongside the team or independently. In addition, there have been two visits from the Medical Director's Office involving senior teams. DMT walkarounds continue to be supported. | Completed (Done) |
| 13.1 | Reinforce WHO checklist use in Cath labs and monitor compliance (duplicate recommendation). | The review team recommends that the mandatory use of a WHO checklist is reinforced as standard practice for the Cath labs moving forward and that compliance is audited and monitored. | | | | This is duplicate of recommendation 2.4. | De-Scoped |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 13.2 | Standardise COW model delivery to ensure consistent patient and staff experience. | Agree on standardised delivery of COW model based on daily timetable of duties, to ensure consistency of experience for patients, residents, and nursing team. Differential engagement cannot be allowed to continue. | Consistent, reliable, and high-quality experience for patients, residents, and the nursing team by agreeing and implementing a standardised Consultant of the Week model. | A single, standardised Consultant of the Week model is agreed and adopted across the directorate. Consistent consultant engagement and visibility throughout the week. Reduced variation in how duties are delivered, improving continuity of care and team coordination. Improved experience for patients and clearer expectations for residents and nursing staff. | Sunday, September 28, 2025 | Feb 2026: The COW model is implemented. A clearly defined SOP has been developed and is consistently reviewed, current version 2.0. | Completed (Done) |
| 13.3 | Hold 6-monthly reviews of COW effectiveness with stakeholder feedback. | There should be as a minimum a 6-monthly review with feedback from all stakeholders on the effectiveness of COW. | Effectiveness of COW model is reviewed every 6 months and feedback acted on. | Effective COW model. Consistent reviews and improvement. | Thursday, October 30, 2025 | Model continues to be updated. Checklist incorporated to daily Board Round to ensure consistency in delivery of Consultant of the Week. | Completed (Done) |
| 13.4 | Assess COW model benefits for cardiology and wider system. | The directorate team should analyse the benefits of the COW model to Cardiology and the wider system. | The impact and value of the Consultant of the Week (COW) model is clearly understood within the wider system. | Clear evidence on how the COW model affects patient flow, safety, staff experience, and system efficiency. Informed decision-making on the future use or adaptation of the COW model in Cardiology. | Wednesday, January 28, 2026 | The Directorate is supporting the implementation of Ward Standards, as part of Urgent and Emergency Care programme. Plan to implement Standards Bundle on B1 Ward. | Completed (Done) |
| 14 | Make waiting list management engagement mandatory for all consultants. | The review team recommends that engagement in waiting list management is compulsory for all consultants. | Consistent, fair, and effective management of waiting lists. | All consultants actively participate in waiting list management as part of their core duties. Improved equity, timeliness, and oversight of patient scheduling and access to care. Enhanced team coordination and more sustainable management of demand and capacity. | Wednesday, September 23, 2026 | The consultant team has commenced active triage of GP referrals, supported by planned sessions, and condition specific pathway development is in progress. Operational data is being generated to inform waiting list management. While progress is evident, further work is required to secure sustained and measurable improvement. | In Progress |
| 15 | Require evidence of mandatory training completion during appraisal/job planning. | The directorate should require evidence of completion or mandatory training by all employees as part of the appraisal or job-planning process. | Increased and sustained compliance with mandatory training across all staff groups. | Improved assurance of workforce competence, safety, and regulatory alignment. Greater accountability through consistent inclusion of training compliance in appraisal and job-planning discussions. Reduced organisational risk linked to missed or overdue mandatory training. | Friday, March 20, 2026 | March 2026: Mandatory training is incorporated into the job planning process, and all required training must be completed before the job plan review takes place. Monitoring systems are already in place, and therefore this recommendation is agreed as complete. | Completed (Done) |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 16 | Include equity as a standing agenda item in directorate meetings. | It is recommended that the directorate include an agenda item through their directorate meetings that covers equity for Staff. Variation should be limited where possible, and equity pursued in all aspects. | Equity is consistently considered, monitored, and embedded across all aspects of the Cardiology Directorate. | Increased visibility and prioritisation of equity issues affecting staff.<br>Strengthened culture of inclusivity and consistency across all Cardiology teams. | Monday, February 2, 2026 | Feb 2026: This has been completed and all groups are included. | Completed (Done) |
| 17 | Implement leadership and management training across the directorate. | Leadership should be the responsibility of a team. A programme of management and leadership training including organisational architecture, should be implemented for the whole directorate. | To embed a shared, team-based approach to leadership across the Cardiology Directorate. | Stronger collective leadership, reducing reliance on individuals and improving resilience. Consistent leadership capability across professional groups and subspecialties. Improved understanding of organisational structures, roles, and governance pathways. | | Further work is underway to expand the clinical leadership structure within cardiology, including defining new consultant leadership roles and appointing an interim Clinical Director. This builds on the 24 March 2026 progress, where leadership development initiatives were being implemented, supported by a suggested TNA and broader opportunities across the team. With the recommendation now closed, ongoing leadership development and monitoring will transition into normal VBA and business as usual activity. | Completed (Done) |
| 18 | Redesign cardiology leadership model with clear roles and responsibilities. | The leadership model should be redesigned for Cardiology. As part of this Physiology should have a single lead individual with the appropriate clinical background and managerial capability. Within the medical group a leadership team should be formalised with a single clinical director. There are a number of options to fulfil this team approach with either subspecialty leads or leads for functions within the department. Any extra SPA should only be allocated to job plans once the sessions highlighted above are prioritised. | A resilient team-based structure that supports effective decision-making and service delivery. | A strengthened, clearly defined leadership structure for Cardiology.<br>A single, clinically, and managerially competent lead for Physiology to support cohesive direction and professional oversight. A formalised medical leadership team with a designated Clinical Director and agreed leadership roles. Improved clarity of responsibilities across subspecialty or functional leadership areas. | | March 2026: The leadership model has been defined. There is an educational lead, Clinical Audit lead, Morbidity and Mortality lead in place which are evolving roles. Physiology Clinical lead appointed. | Completed (Done) |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 19.1 | Review demand and capacity assumptions with Cardiff University for future planning. | The directorate and clinical board need to review the demand and capacity work with Cardiff university to ensure that the assumptions are correct going forward. They currently assume no change in practice. This should inform a rightsizing piece of work for Cardiology. | | | | This recommendation will be covered in recommendation 3. Demand and Capacity review. | De-Scoped |
| 19.2 | Improve outpatient pathways and primary care interface in line with best practice. | Within Outpatients the adoption of pathways and the role of interface with primary care needs consideration linking to best practice in Wales and the UK. | Improved outpatient effectiveness and patient flow by reviewing and adopting best-practice pathways and strengthening the interface with primary care, ensuring alignment with leading models in Wales and the UK. | Outpatient pathways are clearer, more consistent, and aligned with national best practice.<br>Stronger and more efficient communication and collaboration with primary care.<br>Reduced unnecessary referrals and improved appropriateness of patients seen in secondary care.<br>Improved patient experience through more streamlined and predictable pathways.<br>Better use of outpatient capacity, supporting timelier access and service sustainability. | Wednesday, December 30, 2026 | This is in progress since September 2025, scope includes: development of a discreet patient pathways for conditions and enhanced triage for management of GP referrals. | In Progress |
| 19.3 | Review pacing lab infrastructure ahead of move to theatre 6. | The current infrastructure of the pacing lab has been reported to be suboptimal and should be reviewed in line with its planned move to theatre 6. | Pacing lab meets clinical, safety, and operational requirements. | Clear identification of current infrastructure limitations and required improvements. A defined plan aligning pacing lab facilities with the capabilities of Theatre 6. A smooth and well-coordinated transition that minimises disruption to pacing procedures. | Tuesday, July 28, 2026 | This is partially completed: The pacing lab has moved to the short stay surgical unit. | In Progress |
| 19.4 | Develop expansion plan based on demand and capacity data, including 7-day working. | Demand and capacity information should be acted upon and a coherent plan developed for expansion. This should include options for 7 day working and/or expansion. Within this links should be made to the wider availability of imaging equipment in the health board. | Demand and capacity information to develop a coherent, future-focused expansion plan for the service. | Clear understanding of current and future demand on the service. An evidence-based plan outlining expansion options, including 7-day working. Improved alignment with imaging availability across the health board. Enhanced capacity and patient flow through more efficient use of resources. | Thursday, December 31, 2026 | 2 NHS locum interventional consultants appointed to increase commissioned PCI activity; team exploring option for bank holiday lists and Saturday lists. | In Progress |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 20 | Review and improve cardiology stock management and procurement processes. | The review Team recommends that there is an entire review of the stock management and procurement process (including scan for safety) in cardiology so that the process is made safe and efficient. | Stock management and procurement within Cardiology is safe, efficient, and well-controlled. | Clear identification of weaknesses and risks within current stock management and procurement processes. A streamlined, standardised, and safer stock management system, supported by Scan for Safety principles. Reduced waste, improved traceability, and more efficient use of resources. Improved availability of essential equipment, supporting smoother clinical workflows and patient car. | Tuesday, September 29, 2026 | First draft of improvement plan in relation to stock management and prohibited use of expired devices completed. Scan for safety - basic scanning of stock and assign to patient training completed, this process is now underway. Phase two planned for w/c 11/05/2026 stock management and wastage. | In Progress |
| 21 | Review on-call arrangements across all professions for safety and consistency. | The cardiology directorate should conduct a review of on-call arrangements across all professions to ensure consistency, sustainability, and safe practice across all specialties. | On-call arrangements across all professional groups within Cardiology are consistent, sustainable, and safe practice across all sub-specialties. | Clear understanding of current on-call models. More consistent and equitable on-call arrangements. | Friday, October 30, 2026 | Complete a review of the current on-call arrangements and present findings. Work is underway and will require consistent evaluation. This will transition into business-as-usual activity. Project team need to identify at which point that the recommendation can be closed. | In Progress |
| 22.1 | Conduct job planning for consultant workforce to reflect all work types. | Cardiology Directorate to conduct job-planning exercise for the cardiology consultant workforce, to reflect clinical & non-clinical work. | All job plan reviewed and updated to reflect clinical and non-clinical work. | Transparent, consistent job plans that reflect the full scope of consultant activity, including clinical commitments, leadership roles, teaching, training, and SPA time. Improved alignment between consultant capacity and service requirements, supporting safe and sustainable delivery. Greater clarity on expectations, responsibilities, and protected time for non-clinical work. Enhanced ability to plan, monitor, and optimise consultant workforce resource. | Wednesday, September 30, 2026 | Job planning is currently underway, with a primary focus on cardiac and thoracic surgery. All job plans are scheduled over the next three months. Next steps: - Completion of job planning for Cardiac and thoracic teams and agree next priority area. | In Progress |
| 22.2 | Facilitate job planning meetings to align consultant work with departmental needs. | Job-planning meetings to be facilitated by Clinical Director and General Manager for cardiology to ensure that the needs of the department match the work being asked of consultants. | Job plans are aligned to departmental needs by facilitating structured job-planning meetings. | Clearer expectations and shared understanding between consultants and management regarding clinical and non-clinical commitments. Strengthened collaboration and transparency in the job-planning process. | Tuesday, September 30, 2025 | March 2026: This is completed - Job planning meetings are jointly delivered by the Clinical Director and General Manager. 14/04 - in line with 22.1. | Completed (Done) |
| 22.3 | Ensure all job plans are current and signed off in Allocate system. | All job plans should be up to date and signed on Allocate system so that consultant work can be delivered efficiently and in a way that supports good service delivery. | Consultant job plans are current, accurate, and formally signed off within the Allocate system. | All consultant job plans up to date and approved on Allocate, providing a single, accurate source of workforce information. Improved efficiency and coordination of consultant activity through clearer, validated job-plan data. Enhanced ability to match consultant capacity to service needs, improving operational performance. Greater transparency and assurance around consultant commitments and resource utilisation. | Wednesday, September 30, 2026 | In progress. 14/04/ - In line with 22.1. | In Progress |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 22.4 | Define SPA activity clearly and align non-core SPA with directorate goals. | Ensure SPA activity is well-defined within individual job plans and non-Core SPA activity is aligned with the objectives and goals of the directorate. Priority SPA should be assigned first as detailed above. | SPA activity is clearly defined within individual job plans, with non-core SPA time. | Clear distinction between core and non-core SPA activities in all job plans.<br>Directorate objectives are supported through aligned non-core SPA activities.<br>Improved transparency and consistency in SPA allocation across the workforce. | Wednesday, September 30, 2026 | In progress. 14/04- In line with 22.1. | In Progress |
| 22.5 | Standardise core SPA allocation to 1.5 sessions for full-time consultants. | Standardise Core SPA allocation to 1.5 sessions for all full-time consultants. | Create consistency, equity, and clarity across consultant job plans by standardising Core SPA allocation to 1.5 sessions for all full-time consultants. | Consistent application of Core SPA time across all full-time consultant roles.<br>Improved transparency and fairness in job planning. | Monday, September 29, 2025 | Feb 2026: All fulltime consultants have 1.5 session allocated for Core SPA as per the Welsh Consultant Contract. This has been defined within Allocate job planning records as job plans are updated. | Completed (Done) |
| 22.6 | Use SMART objectives in Allocate to define non-core SPA responsibilities. | Use the Personal Outcomes section of Allocate job plan to define responsibilities and output for Non-Core SPA, using SMART objectives. | Personal Outcomes section in Allocate is used and responsibilities are clearly defined. | Non-Core SPA responsibilities are transparent and consistently documented.<br>SMART objectives provide measurable outputs and clearer expectations.<br>Improved alignment of SPA activity with directorate and organisational priorities.<br>Enhanced ability to monitor progress and evidence achievement of Non-Core SPA work. | Wednesday, September 30, 2026 | This is in progress. As we job plan with Consultants - the Personal Objectives section is being updated. 14/04 - In line with 22.1. | In Progress |
| 22.7 | Share DCC tariffs and job plan details on SharePoint for transparency. | Sharing of DCC tariffs and details within job plans on directorate SharePoint or Intranet page should be considered to demonstrate transparency, fairness, and equity. | Transparency, fairness, and equity in job planning by sharing DCC tariffs and related job plan details on the Directorate SharePoint or intranet. | Staff have clear visibility of DCC tariffs and how they are applied in job plans.<br>Increased trust and confidence in job-planning processes through openness and consistency. | Wednesday, August 26, 2026 | This is linked to the job planning recommendations in Foundations for change phase. | Not Started |
| 22.8 | Update job plans to reflect correct on-call banding. | All job-plans updated on Allocate to reflect correct on-call banding | To ensure accuracy, consistency and compliance in job planning by updating all job plans on Allocate to reflect the correct on-call banding. | All consultant job plans display correct and up-to-date on-call banding.<br>Improved accuracy in workforce data, job planning, and rota management.<br>Reduced discrepancies in pay, workload expectations, and contractual compliance.<br>Enhanced transparency for consultants, managers, and workforce teams. | Monday, June 29, 2026 | This is in progress. | In Progress |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 22.9 | Conduct diary exercise to ensure on-call allowances match service demands. | Conduct diary exercise for interventional and non-interventional cardiologist groups to ensure on-call sessional allowance accurately reflects service demands. The intensity of the on call should be reflected in the job plan to ensure adequate rest. | On-call sessional allowances accurately reflect the true intensity and demands of the service. | Accurate representation of on-call workload for both interventional and non-interventional teams. Fair and evidence-based sessional allowances aligned to actual service intensity. Greater transparency and equity in on-call arrangements across consultant groups. | | This recommendation is aligned to the Cath Lab transformation programme. | Not Started |
| 23 | Ensure VBA completion at all levels as a supervisory priority. | The Management team should ensure completion of VBAs at all levels to ensure equity and this needs to be a key objective of everyone in a supervisory role. | Fairness, consistency, and accountability across the directorate by achieving full completion of VBAs at all levels. | Increased equity and standardisation in staff appraisal and development.<br>Clear accountability for supervisors in completing and maintaining VBAs.<br>Improved oversight of performance, development needs, and workforce planning | Wednesday, May 27, 2026 | VBA training has been successfully completed for Band 7 and Band 8 staff, with the next phase focusing on rollout to Band 6 colleagues. VBA performance data continues to be reviewed monthly at DMT meetings, ensuring ongoing oversight and accountability. A workforce performance dashboard is currently in development to provide real-time visibility and enhance monitoring within DMT forums. Comparative analysis against the previous year demonstrates overall improvement, while also identifying hotspot areas requiring targeted intervention and further support. Ongoing engagement with these hotspot areas is in place to drive continuous improvement. | In Progress |
| 24 | Allocate staff to lead physiologists for fair VBA supervision. | The allocation of staff to each lead physiologist for the purpose of VBA supervision should be addressed so that it is consistent and ensures fairness and equity of workload. | Equitable and consistent performance management by achieving full completion of VBAs at all levels. | VBA completion becomes standard practice across the directorate. Greater consistency and fairness in staff appraisal and development. Clear accountability for supervisors in meeting appraisal expectation. | Monday, March 30, 2026 | VBA training for Band 8a staff has been provided. Meeting has been arranged with the Band 7 staff to discuss their training/support needs. A timetable will be produced by end of March, and the weekly monitoring is in place. | In Progress |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 25 | Embed escalation tracking and clarify accountability for action plans. | The review team recommends that a process is embedded with the directorate and clinical board to track escalations and decisions. Aligned to this there needs to be greater clarity on accountability for the completion of action plans from inspections. It is best done within the performance review process and the outcome of this needs to be visible to all of the teams within Cardiology and to the executive team. This work should be aligned to the development of the quality management system (recommendation 36). | Clear and accountable process for tracking escalations and decisions across the Directorate and Clinical Board. | Escalations and decisions are consistently tracked and visible to Cardiology teams and the executive. Clear accountability for completing inspection-related action plans. Improved governance through integration with the performance review process. Stronger alignment with the quality management system to support sustained improvement. | Monday, September 29, 2025 | Update 18th Feb 2026: Operational escalations and decisions are managed through the DMT, with actions tracked via meeting minutes and action log. Inspections from HEIW and queries from the JCC are overseen collaboratively by the clinical teams and the DMT, with regular written reports provided to both partner organisations. These processes have strengthened governance within the DMT and improved links with the clinical teams. | Completed (Done) |
| 26 | Hold monthly Quality & Safety meetings with full attendance and minutes. | Directorate Quality and Safety meetings must be held at least monthly, to be chaired by the directorate Q&S lead, be fully minuted and should require attendance by all clinical and management staff; all non-emergency work should be cancelled to facilitate attendance. | Consistent, high-quality governance by holding monthly Directorate Quality & Safety meetings that are fully minuted, chaired by the Q&S lead, and attended by all clinical and management staff. | Regular, well-governed Q&S meetings take place with full attendance and clear documentation. Improved oversight, transparency, and shared accountability for quality and safety across the directorate. | Wednesday, May 28, 2025 | Feb 2026: The Q&S lead was appointed in 2025, and meetings have been set with a clear agenda. | Completed (Done) |
| 27 | Include thematic analysis of concerns and incidents in Q&S meetings. | Thematic analysis of patient concerns, clinical incidents and nationally reportable incidents should be a standing agenda item at directorate Q&S meetings. | Strengthened governance and learning by making thematic analysis of patient concerns, clinical incidents, and nationally reportable incidents. | Regular thematic analysis informs decision-making and improvement actions. Earlier identification of trends, risks, and recurring issues. Enhanced transparency, shared learning, and accountability across the directorate. | Thursday, January 29, 2026 | Feb 2026: A rolling agenda programme has been established for DMT meetings, and Quality & Safety issues can be raised at any meeting. In addition, one DMT meeting each month is dedicated specifically to a Quality & Safety agenda. | Completed (Done) |
| 28 | Improve clinical incident reporting across the directorate. | A programme of improving clinical incident reporting should be implemented by the directorate. | Strengthen patient safety and learning by implementing a directorate-wide programme that improves the quality and frequency of clinical incident reporting. | Increased and more consistent reporting of clinical incidents across all services.<br>Improved understanding of themes, risks, and learning opportunities.<br>Enhanced safety culture through proactive identification and management of issues. | Sunday, January 31, 2027 | March 2026: Datix reporting has increased, with more staff now able to access and lead on Datix processes. Our partnership with Patient Safety has strengthened, and managers are being well supported to use Datix effectively. | Completed (Done) |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 29 | Foster a just culture to support transparency and care improvement. | A supportive, just culture should be fostered to encourage transparency and a commitment to improving care. | A supportive, just culture that encourages openness, learning, and shared responsibility, enabling staff to feel safe to speak up and committed to improving care. | Update 24th March 2026: | Sunday, March 29, 2026 | March 2026: Trainees are increasingly speaking up, with appropriate actions taken in response to issues raised. Senior teams Walk-abouts take place every Tuesday, and Safe to Speak Up awareness has increased significantly. There has also been an increase in executive walkabouts and incident reporting. Trade Union drop-ins have expanded, and key messages are now incorporated into staff induction. There is a consistent flow of engagement through the SharePoint site. Weekly cardiology trainee feedback surveys are in place, and stakeholder groups are being actively used as part of senior appointment and interview processes. | Completed (Done) |
| 30 | Update cardiology risk register to reflect current service risks. | Update Directorate's risk register to reflect current risks across all components of the cardiology and cardiac Physiology service. | Effective governance and oversight by updating the Directorate risk register so it accurately reflects current risks across all areas of the Cardiology and Cardiac Physiology service. | A comprehensive and up-to-date risk register covering all components of the service. Improved visibility of emerging and ongoing risks to support informed decision-making. Strengthened assurance and accountability through accurate monitoring and mitigation of key risks. | Thursday, November 27, 2025 | Feb 2026: The risk register has been updated, and all risk will be transferred to AMaT where risks will be managed electronically. | Completed (Done) |
| 31 | Make risk register a standard item in Q&S meetings. | Include risk register as a standard agenda item on every quality and safety meeting for cardiology directorates. | Strengthen governance and ensure consistent oversight by making the Directorate risk register a standing agenda item at every Cardiology Quality & Safety meeting. | Regular review of risks enhances awareness, accountability, and timely mitigation. Improved visibility of emerging and ongoing risks across the directorate. Stronger, more reliable Quality & Safety governance through consistent monitoring. | Friday, January 30, 2026 | March 2026: Dave Hanna will speak to Richard Wheeler regarding adding this to the Q&S agenda. High scoring risks are on the meeting agenda. All trained using AMaT. It is an agenda item on the DMT meeting. Based on recognition that this is the best place for it. | Completed (Done) |
| 32.1 | Review NRIs from 2019–2024 and address outstanding actions. | Directorate team to review all NRIs between 2019 and 2024 and identify any actions which have not been implemented. | Learning, assurance, and improved safety by reviewing all NRIs from 2019–2024 and identifying any actions that remain outstanding. | | Sunday, March 29, 2026 | March 2026: This is part of the Q&S function. Also, agenda item in DMT, Monthly meetings with Patient Safety to ensure compliance. Further training for DMT delivered. NRI's fed through Monthly Q&S. | Completed (Done) |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 32.2 | Provide evidence of implementing Learning Review recommendations. | Directorate to provide evidence of implementation of recommendations of Learning Reviews. | Strengthened governance and assurance by implementing all recommendations arising from Learning Reviews. | Documented evidence confirming that Learning Review recommendations have been acted on and embedded in practice. Improved organisational learning and accountability.<br>Greater assurance that identified risks have been addressed and patient safety has been enhanced. | Tuesday, June 29, 2027 | March 2026: This is in progress and part of the scope for the QMS prototyping. | In Progress |
| 33 | Adopt EU Whiteboard or similar for acute cardiology referrals. | Adoption of EU Whiteboard, or similar, for all acute referrals from emergency unit to cardiology. | Improve visibility, safety, and coordination of acute referrals from the Emergency Unit to Cardiology. | All acute cardiology referrals are logged, visible, and tracked in real time. Improved communication and handover between Emergency Unit and Cardiology teams. Reduced missed or delayed referrals and enhanced patient flow. | Wednesday, April 29, 2026 | The infrastructure is in place; software has been installed on ward pc's - Cardiology formally went live on 1st April. Baseline data has been captured to support the measurement of improvement. Work is ongoing with IT development team to establish a separate reporting stream for cardiology and thoracic, which are currently combined within the dataset. Usage and demand will continue to be monitored are reviewed. | Completed (Done) |
| 34 | Review workload of on-call cardiology registrars. | Directorate to conduct review of workload of on-call cardiology registrars (highlighted as an ongoing issue during Review). | Safe, sustainable, and equitable workload for on-call cardiology registrars. | Clear understanding of registrar on-call workload, pressures, and risk areas. Evidence-based actions identified to improve rota sustainability and wellbeing. | Wednesday, December 30, 2026 | To support the development of this recommendation, Cardiology went live on the 1st of April with consistent use of E-whiteboard system. Baseline performance and usage data have been reviewed and will be tracked to measure implementation success. Work is ongoing with the IT Development Team to create separate streams for cardiology and thoracic services, to provide accurate data streaming. Next Steps - Continue to monitor system usage and data collection. A minimum of 3-4 months data is required to support further development of this recommendation. | In Progress |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 35.1 | Appoint Q&S lead to review audit programmes and ensure compliance. | A review of local and national audit programmes should be conducted by a newly appointed lead for Quality and Safety within the Cardiology Directorate and a plan implemented for ensuring compliance which includes job planned time and evidence of consistent contribution. | Strengthened governance, assurance, and compliance by reviewing all local and national audit programmes. | Comprehensive understanding of current audit activity, gaps, and compliance levels. Clear expectations for audit participation supported by job-planned time. Consistent and evidenced contribution to audit across the directorate. Improved alignment of audit activity with quality, safety, and service priorities. | Thursday, December 31, 2026 | This is in progress; part of Q&S programme and QMS prototype programme; Devices workstream examining mechanisms for automating dataflow to NICOR dataset for Device. | In Progress |
| 35.2 | Make audit a fixed agenda item in Q&S meetings. | Local and National audit should be a fixed agenda item on the regular directorate Quality and Safety meetings. | Local and National audits are a fixed agenda on the Directorate Quality and Safety meetings. | Regular, structured review of audit activity and findings. Improved assurance that audit actions are tracked, completed, and inform quality improvement. Enhanced visibility of audit priorities and compliance across the directorate. | Friday, May 29, 2026 | Audit presentation within the Q&S is now in place. Additional work is required to formally agree the national and local audits in place and to establish how these are embedded within the directorate Q&S forum, to ensure a consistent and robust approach. | In Progress |
| 35.3 | Use local audit to target areas needing improvement. | The local audit programme should be used to target areas of practice or outcomes which are believed to require improvement or have been a contributing factor to poor patient outcomes or reported incidents. | Local audit programme is used proactively to identify and address areas of practice or outcomes that require improvement. | Audit activity is targeted at priority areas where improvements are needed. Clear identification of practice issues contributing to adverse outcomes or incidents. Evidence-based actions are developed to address gaps and strengthen patient care. Improved quality, safety, and consistency of clinical practice across the directorate. | Tuesday, June 30, 2026 | This is in progress and part of the scope for the QMS prototyping. | In Progress |
| 36 | Develop a quality management system to sustain improvements. | Considering the extent of work required to improve the quality and safety processes and the recommendations within this review there is an opportunity to embed a quality management system to sustain the changes required. This should be developed in line with how responses to regulatory inspections are managed within other parts of the organisation. | Established and sustainable quality management system that supports ongoing improvements in quality and safety and aligns with organisational approaches to regulatory oversight. | A structured and sustainable quality management system is in place to support continuous improvement. Improvements identified in the review are embedded and maintained over time. | Monday, May 31, 2027 | This is in progress and part of the scope for the QMS prototyping. | In Progress |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 37 | Assign named clinical supervisors to resident doctors. | Each resident doctor working in the cardiology department to have a named clinical supervisor who is a consultant cardiologist and who will conduct formal clinical supervision meetings during the period of the resident doctor's rotation in Cardiology. | Resident doctors in Cardiology receive consistent, high-quality supervision by assigning each a named consultant cardiologist. | Every resident doctor has a clearly identified clinical supervisor.<br>Regular, documented supervision meetings take place, supporting development, performance, and patient safety. | Thursday, December 4, 2025 | Feb 2026: This has been completed. | Completed (Done) |
| 38 | Include Speaking Up Safely in resident doctor induction. | Resident doctor induction to include session of Speaking Up Safely, including how to use this service. | Increased awareness and encouraged routine use of the Speaking Up Safely process across the Cardiology Directorate. | Improved staff confidence in raising concerns promptly and appropriately.<br>Greater visibility and uptake of the Speaking Up Safely pathway.<br>Enhanced culture of openness, psychological safety, and early problem-identification. | Monday, June 29, 2026 | This is in progress. | In Progress |
| 39 | Continue weekly SHO feedback, collated by non-clinical staff. | Continue weekly SHO feedback questionnaire but results to be collated by non-clinical team members e.g. directorate managers. | Strengthened learning and improve supervision by continuing the weekly SHO feedback questionnaire. | Consistent collection and objective collation of SHO feedback.<br>Improved oversight of trainee experience and identification of issues or themes. More reliable data to inform service improvements and support clinical teams. | Monday, March 30, 2026 | March 2026: Work has begun, and the feedback questionnaire is already in place. The platform is being moved to Microsoft Forms and will be managed by the DMT team, removing the risk of bias associated with the process being led by the consultant team. This has restarted on 20th March 2026. | Completed (Done) |
| 40 | Share planned cardiology investments with HEIW. | Health Board to share details of any planned investments in the cardiology service with HEIW e.g. 4th Catheter Laboratory, further consultant recruitment. | Support strategic workforce and service planning by ensuring the Health Board shares details of any planned investments in the cardiology service. | HEIW has clear visibility of planned service developments and investment priorities. Improved alignment between workforce planning, training capacity, and future service needs. Stronger collaboration between the Health Board and HEIW, supporting sustainable service growth. | Monday, September 29, 2025 | March 2026: This is now complete. Six-monthly meetings with HEIW are underway, and pre-meeting reports are being submitted in advance, providing updates on service improvements and progress against recommendations. | Completed (Done) |
| 41 | Ensure equal access to learning in pacing, intervention, and electrophysiology. | Ensure there is unimpeded access to learning opportunities in pacing, interventional cardiology, and electrophysiology for resident doctors, irrespective of which operator is leading the procedure. | Resident doctors have full and equitable access to learning opportunities in pacing, interventional cardiology, and electrophysiology, regardless of which operator is leading the procedure. | Resident doctors can attend and learn from procedures without restriction or variability.<br>Improved, consistent training exposure across all key cardiology subspecialties.<br>A fair and supportive learning environment that maximises educational opportunities for all residents. | Monday, September 29, 2025 | Feb 2026: This has now been completed. | Completed (Done) |

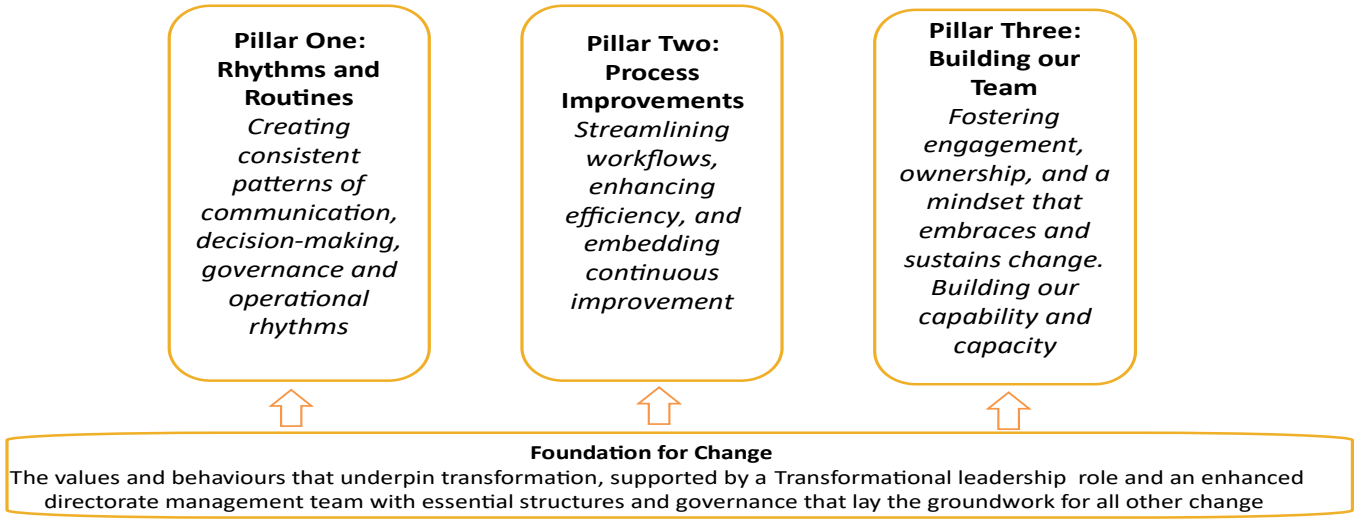
| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 42 | Formalise mitigations if training is limited by service capacity. | Ensure mitigations are formalised and in place if service capacity is limiting training opportunities e.g. in ablation | Ensure training opportunities are maintained despite service capacity constraints | | Monday, March 1, 2027 | March 2026: There is currently no electrophysiology trainees allocated to UHW, in view of limited training opportunities however we are appointing a 3rd ep consultant which will improve training opportunities. Date for new consultant 22 March 2026. | Completed (Done) |
| 43 | Update and maintain online Cardiology Handbook. | Update Cardiology Handbook online and ensure regular updates | Staff have access to accurate, up-to-date online Cardiology Handbook | The Cardiology Handbook is current, accurate, and reflects best practice.<br>Staff have reliable access to essential clinical and operational information.<br>A regular update schedule is in place, ensuring information remains relevant over time. | Monday, December 7, 2026 | All SOPs and guidelines are currently going through a process of review, audit, and updating as part of the Q&S and QMS work. | In Progress |
| 44 | Migrate content of Cardiology Handbook for Cardiology onto a SharePoint page and EOLAS app to enable ease of access for residents. | Migrate content of Cardiology Handbook for Cardiology onto a SharePoint page and EOLAS app to enable ease of access for residents. | The Cardiology Directorate must complete a comprehensive review of on-call arrangements across all professional groups to ensure that practice is consistent, sustainable, and safe for all specialties. | Cardiology Handbook content fully migrated to SharePoint and EOLAS. Staff awareness and access enabled across both platforms. Process in place for ongoing updates and content governance. | | In progress, migration of the Cardiology Handbook to SharePoint underway. | In Progress |
| 45 | Formalise cover for registrar bleep during out-of-hours sickness. | Formalise arrangement for covering Cardiology registrar bleep if there is sickness during the out of hours period | Safe and consistent out-of-hours cardiology cover for registrar bleep cover during sickness absence. | Clear, reliable processes are in place for covering the cardiology registrar bleep during out-of-hours sickness.<br>Reduced risk to patient care through uninterrupted clinical cover. Improved clarity and confidence for staff regarding escalation and rota arrangement. | Tuesday, April 28, 2026 | March 2026: This is in progress - discussions are taking place. | Completed (Done) |
| 46 | Ensure fair outpatient workload between consultants and residents. | Ensure equity of workload between consultants and residents in outpatient clinics. | Fair and balanced distribution of outpatient clinic workload between consultants and residents. | Workload is shared equitably, improving efficiency and team cohesion.<br>Residents receive appropriate training opportunities without being overburdened. Consultants have clearer, more balanced clinic responsibilities aligned to service needs | Thursday, October 30, 2025 | Feb 2026: Completed SOP has been produced. | Completed (Done) |

| Rec. | Recommendation | Description | Aim | Deliverable Outcomes | Expected Completion Date | Updates | Status |
|---|---|---|---|---|---|---|---|
| 47 | Share Wednesday teaching topics in advance and align with junior needs. | Ensure topics & programme for weekly Wednesday teaching sessions provided by ward registrars are circulated in advance and align with learning needs of junior residents. | Weekly Wednesday teaching sessions are well-planned and aligned with junior residents' learning needs by circulating topics and the programme in advance. | Teaching topics and schedules are shared ahead of time, improving preparation for all attendees. Sessions consistently reflect the educational needs of junior residents. Enhanced quality, relevance, and engagement in weekly teaching. | Monday, June 29, 2026 | Multiple education opportunities available for trainees in the week; these include regular scheduled teaching such as echo and Friday academic meeting which has its agenda circulated in advance. Weds teaching sessions depend on composition of clinical teams on the ward, area of expertise and patient caseload, this will remain the team will retain flexibility around teaching topics each week. | In Progress |
| 48 | Consider moving junior doctor start time to 08:00 to match consultants. | Consider moving SHO/junior doctor start times to 0800hrs in line with consultants and other inpatient specialties (would enable attendance at some 0800hrs teaching sessions where service constraints permit and facilitate finish at 1600hrs). | | | | Feb 2026: This is de-scoped because the current SHO rota is designed to align with the cardiology service model, including the 09:00 board round each morning. | De-Scoped |
| 49 | Maintain and circulate weekly calendar of training opportunities. | Directorate team to maintain calendar detailing training opportunities including theatre lists, multi-disciplinary team meetings, educational meetings, academic meeting, trainee forums and circulate to resident team on a weekly basis. | Awareness and uptake of training opportunities is increased by maintaining a weekly calendar of theatre lists, MDT meetings, educational sessions, academic meetings, and trainee forums, and circulating it to the resident team. | Residents receive timely, clear information on all available training opportunities each week. Improved attendance and engagement in educational and clinical training activities.<br>More equitable access to learning opportunities across the resident team.<br>Better planning and integration of training within clinical commitments. | Saturday, September 5, 2026 | | Not Started |

## Appendix 1: Project Framework and Governance

To support effective delivery of the Cardiology Improvement Programme, a pillar-based governance and delivery framework has been adopted. This approach provides a clear, structured method for organising a complex programme of work and ensures that delivery remains aligned to strategic priorities while supporting strong oversight and assurance.

The Cardiology Review recommendations have been divided into three pillars to enable clear delivery and logical sequencing of the work. This approach provides structure, clarity, and strong governance, ensuring recommendations are aligned, manageable and delivered in a coordinated way.



## Governance Framework:

### Monthly Project Board

**Function**:

Strategic oversight and decision-making

**Members**:

SRO, Project Team and Directorate.

**Responsibilities** :

- Recommendation updates
- Review progress and risks.
- Funding and resource decisions.

### Weekly Scrum

**Function** :

Operational coordination and agile delivery

**Members**:

Project Team

**Responsibilities** :

- Progress updates from subject matter experts.
- Issue resolution.
- Resource management.

### Task and Finish Groups

**Function**:

Specialised delivery of recommendations within a Pillar

**Members**:

Subject matter experts, cross-functional team members.

**Responsibilities** :

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

### Checkpoint Reviews

**Function**:

Periodic review of progress across Pillars

**Members**:

Representatives from all governance layers.

**Responsibilities** :

- Evaluate outcomes and lessons learned.
- Adjust delivery plans where appropriate.

## Appendix 2: Risks and Issue Summary

### Open Risks

| ID | Description | Cause/Impact | Current Rating | Mitigation |
|---|---|---|---|---|
| 01 | There is a risk that the wider transformational work could draw focus, capacity, and leadership attention away from the delivery of the recommendations. Both areas are important and interconnected, but the scale and visibility of the transformational work may unintentionally reduce the time and resources available to progress the recommendations at the required pace. | Overlapping priorities, shared resources, and concurrent delivery timelines across workstreams. Slower delivery of recommendations.<br>Increased pressure on operational teams managing competing demands | 12 | Agree and communicate a clear prioritisation approach across both work areas. Map interdependencies to understand where sequencing or re-balancing is required. Strengthen governance oversight to monitor capacity and avoid priority conflicts. Ensure regular communication to maintain shared understanding of expectations Additional capacity has been secured through two days per week support from a Programme Manager, providing increased oversight, coordination, and delivery support across both work areas. |
| 02 | There is a risk that limited capacity within the Directorate may delay the delivery of key project activities. Reduced availability of staff and competing operational priorities could slow progress across several workstreams, affecting the project's ability to meet planned timelines. | Limited capacity within the Directorate. Delays may necessitate re-prioritisation of activities, extension of the project schedule, or additional support to maintain momentum. This could also impact stakeholder confidence and place increased pressure on existing team members. | 12 | Weekly scrum meetings to review progress and barriers.<br>Review sequencing of the work.<br>Escalation of resource gaps to the SRO and Project board where applicable. Map interdependencies to understand where sequencing or re-balancing is required. Strengthen governance oversight to monitor capacity and avoid priority conflicts. Ensure regular communication to maintain shared understanding of expectations Additional capacity has been secured through two days per week support from a Programme Manager and also support from Shaping Change team. |
| 03 | There is a risk that limited capacity within People & Culture and ECOD reduces the teams' ability to support this project effectively due to competing demands from other programmes and projects. | Delays to decision-making, reviews, and approvals. Delays to decision-making, reviews, and approvals Reduced availability for project support activities<br>Slippage to planned milestones and delivery timelines Increased risk to quality due to compressed timescales or reduced input<br>Potential misalignment between project outcomes and organisational needs | 12 | Weekly scrums are in place with People & Culture and ECOD representatives to review workload, priorities, and emerging capacity pressures.<br>Established governance forums are used to agree priorities, manage dependencies, and resolve conflicts across programmes and projects. |

**Open Issues**

| ID | Description | Cause/Impact | Rating | Actions |
|---|---|---|---|---|
| 01 | Current project activity would benefit from stronger coordination across workstreams. There is a need for improved clarity around planning, ownership, and communication to ensure that activities are aligned, and key dependencies are fully understood | Without enhanced coordination, there is a risk of misaligned work, duplicated effort, unclear responsibilities, and delays in project delivery. | 9 | Additional capacity has been secured through two days per week support from a Programme Manager and also support from Shaping Change team |

[Type here]

| | | | | | |
|---|---|---|---|---|---|
| Report Title: | JACIE Inspection Update | | | Agenda Item No: | *7.2* |
| Meeting: | Quality Committee | Public | x | Meeting Date: | 28th July 2026 |
| | | Private | | | |
| Lead Executive Title: | Paul Bostock - Chief Operating Officer | | | | |
| Report Author/s Title: | Jessica Castle – Director of Operations Specialist Services<br>Katie Innes – Strategic Planning Manager | | | | |

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

**ALERT** *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

Following the September 2025 JACIE inspection, accreditation of the South Wales Blood and Marrow Transplant (SWBMT) Programme was deferred pending delivery of corrective actions. A formal response was submitted to JACIE on 8 July 2026 and the Programme is awaiting the accreditation decision.

Significant progress has been achieved, with all 87 non-compliances addressed and 336 of 340 corrective actions completed (98.8%). Four actions remain at partial compliance status pending completion of longer-term infrastructure and organisational developments.

A residual risk remains until the JACIE Accreditation Committee has reviewed the submitted evidence and communicated its decision. Failure to secure accreditation could result in the cessation of BMT and CAR-T services in Wales, requiring patients to access treatment through English providers with significant implications for patient outcomes, equity of access, workforce sustainability and NHS Wales finances.

The Programme has now completed all actions relating to identified non-compliances and has submitted a comprehensive evidence pack to JACIE demonstrating corrective actions, approved workforce plans, progress against estates developments, strengthened governance arrangements and quality improvements.

**ADVISE** *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

**ASSURE** *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

| **Board/Committee Response Required *(please select only one)*** | | | | | |
|---|---|---|---|---|---|
| **Assurance** | x | **Approval** | | **Information/Noting** | |

**Recommendations**

The Committee is asked to:

- **Note** the submission of the SWBMT Programme response to JACIE on 8 July 2026.
- **Note** the significant progress made to address the inspection findings, including completion of all 87 non-compliances and 98.8% of all corrective actions.
- **Note** the residual risks pending the final accreditation decision.
- Take **assurance** regarding the governance arrangements and mitigating actions currently in place.
- **Note** the ongoing development of contingency arrangements should accreditation not be secured.

**Governance Route *(please list all other Committee/Groups this report has been to)***

| | |
|---|---|
| ***Where** it's been:* | *In various formats – Tertiary Services Development Group, VBRG, SLT, F&P Committee* |

| | |
|---|---|
| ***When** it went:* | *F&P – 20/05/26* |
| ***What** decision was made:* | ▪ *Oversight and support for delivery of corrective actions.*<br>▪ *Approval of workforce investment proposal for commissioner consideration.*<br>▪ *Ongoing monitoring of accreditation risks and mitigation plans* |

## Main Report

*Background & Current Situation*

Further to the report shared at the June Committee, this report provides an update on progress to address the deficits raised in the recent JACIE inspection.

Background

The South Wales Blood and Marrow Transplant (SWBMT) Programme provides specialist blood and marrow transplantation (BMT) and CAR-T therapy services for approximately 80% of the Welsh population and is the only JACIE-accredited programme in Wales. JACIE accreditation is a requirement of the commissioned service specification for BMT services and is also required by manufacturers for delivery of CAR-T therapies.

Following the reaccreditation inspection undertaken in September 2025, the JACIE Accreditation Committee deferred reaccreditation and requested evidence of corrective actions against identified areas of non-compliance and partial compliance. A formal response was submitted by the Programme on 8 July 2026. The Programme is now awaiting a decision from JACIE.

Progress Against Corrective Actions

The Programme has maintained a detailed action tracking system covering all JACIE standards and inspection findings. Actions have been monitored through dedicated governance arrangements and regular executive oversight.

As at 9 July 2026:

| Area | Total Non-Compliances | Completed | Total Actions | Completed | Outstanding |
|---|---|---|---|---|---|
| Clinical (UHW) | 24 | 24 | 47 | 47 | 0 |
| Clinical (Singleton) | 7 | 7 | 23 | 23 | 0 |
| Paediatrics | 7 | 7 | 64 | 64 | 0 |
| Collection | 25 | 25 | 98 | 97 | 1 |
| Processing | 15 | 15 | 74 | 72 | 2 |
| Quality | 9 | 9 | 34 | 33 | 1 |
| **Total** | **87** | **87** | **340** | **336** | **4** |

Key points include:

- 100% of non-compliances have been addressed.
- 98.8% of all corrective actions have been completed.
- There are no overdue actions.
- Remaining actions are classified as partial compliance and relate primarily to longer-term system and infrastructure developments.

Remaining Areas of Partial Compliance

Four actions remain open at partial compliance status and relate to:

- Validation arrangements associated with implementation of the Contronics system (Processing Unit).
- Alarm functionality and associated controls pending full Contronics implementation.
- Storage contingency arrangements linked to future facilities developments.
- Final competency and training documentation requirements.

Evidence of approved plans, progress milestones, mitigating controls and governance oversight has been submitted to JACIE for each of these areas.

Progress Against Key Programme Risks

***Workforce***

A phased workforce investment proposal has been developed and approved through Health Board governance arrangements prior to submission to commissioners. The proposal addresses a number of workforce resilience issues identified during the JACIE inspection, including processing laboratory staffing, specialist nursing capacity, consultant resilience and programme-wide pharmacy support.

***Estates and Infrastructure***

Progress continues against both the Haematology Day Centre development and wider inpatient and ambulatory care proposals. Updated programme information, approved plans and supporting documentation formed part of the evidence submitted to JACIE. Estimated completion of the Haematology Day Centre development is end of the calendar year 2026. A Strategic Outline Case for the inpatient build has been submitted to Welsh Government and feedback is awaited.

***Quality and Governance***

Enhanced governance arrangements are now established across the Programme including strengthened oversight of compliance, training, quality management and cross-organisational working.

Residual Risk

Whilst substantial progress has been achieved, the final accreditation decision remains outside the direct control of the Health Board and Programme.

Residual risks include:

- JACIE determining that the remaining areas of partial compliance require further assurance.
- Delays to infrastructure developments which underpin longer-term sustainability.
- Delays in securing commissioner support for workforce investment proposals.
- Reputational, workforce and financial consequences should accreditation not be secured.

The overall risk rating therefore remains significant pending receipt of the accreditation outcome.

*Service Continuity and Contingency Planning*

The SWBMT Programme, together with representatives from the Specialised Services Clinical Board and Strategic Planning Team, has maintained regular engagement with colleagues from the NHS Wales Joint Commissioning Committee (NWJCC) throughout the accreditation process. These discussions have ensured that commissioners remain fully sighted on both the risks associated with the JACIE accreditation process and the significant progress made in addressing the inspection findings. NWJCC colleagues have been provided with updates on the remaining areas of partial compliance and are currently considering the workforce investment proposal submitted in support of the Programme's long-term sustainability.

Whilst every effort has been made to address the issues identified by JACIE, a residual risk remains, until a formal accreditation decision is received. The potential implications of a loss of accreditation were considered by the NHS Wales Joint Commissioning Committee's Clinical Commissioning Leadership Group (CCLG) in June 2026. CCLG recognised that the consequences would differ between the CAR-T and Blood and Marrow Transplant (BMT) services.

- For CAR-T therapies, accreditation is a prerequisite for treatment delivery and access to product supply, meaning activity would need to be commissioned from alternative JACIE-accredited providers in England.
- For BMT services, two potential options could be considered. The first would be for the Joint Commissioning Committee (JCC) to initiate a decommissioning process and recommission services from JACIE-accredited providers in NHS England. The second would be for Cardiff and Vale University Health Board to seek Board approval for a time-limited derogation from the service specification, enabling local service provision to continue whilst outstanding matters are addressed, subject to approval by the JCC. Any derogation arrangement would be subject to enhanced governance, quality assurance and monitoring requirements.

CCLG also recognised the practical and financial challenges associated with transferring activity outside Wales, including capacity constraints, impacts on patient access and experience, and the need to retain specialist workforce capability within the local service. Whilst any future decision would require detailed appraisal, these factors would be key considerations in determining the most appropriate course of action should accreditation not be awarded.

Should any of these contingency arrangements be required, further work would be necessary to support implementation, including:

- Patient prioritisation, pathway redesign and transfer arrangements.
- Workforce retention, recruitment and redeployment planning.
- Comprehensive communication and engagement plans for patients, staff, stakeholders and partner organisations.
- Detailed financial, operational, quality and equality impact assessments.

NWJCC has advised that the outcome of the JACIE process will be reported through its governance arrangements. Should accreditation not be awarded, commissioners have indicated that a further paper setting out the available commissioning options and recommended way forward will be brought forward for consideration.

Llais has not been formally engaged regarding contingency planning at this stage; however, representatives have been briefed on the Programme's position and the potential risks associated with the accreditation outcome. Further engagement would be undertaken should contingency arrangements need to be progressed.

**Appendices:**

1. JACIE Action Tracker Summary
2. JACIE Submission Metrics (9 July 2026)
3. JACIE Submission – Executive Cover Letter

**Strategic Alignment – Shaping Our Future Wellbeing:**

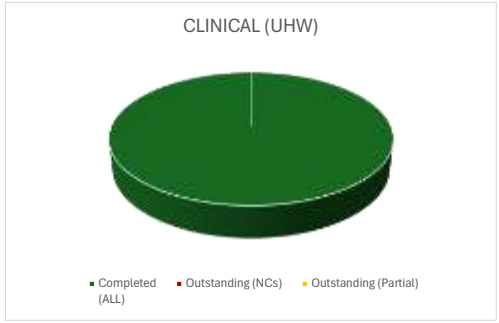
| | | | |
|---|---|---|---|
| Putting People First | x | Providing Outstanding Quality | x |
| Delivering in the Right Places | | Acting for the Future | x |

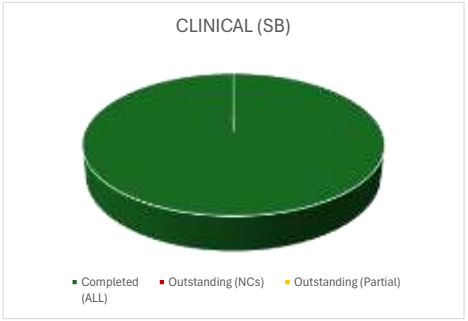
| **Impact Assessment** |
| --- |
| **Risk**: Yes |
| Risk Assessment attached |
| **Safety**: Yes |
| Risk Assessment attached |
| **Financial**: Yes |
| *Business Case to address revenue requirements to be submitted to JCC for consideration – has been to VBRG, SLT and F&P Committee (20/5/26).*<br>*SOC to be developed for capital case.*<br>*Financial risk covered in risk assessment.* |
| **Workforce**: Yes |
| Workforce considerations included in revenue case. Implications will not be fully understood until final decision on accreditation made. |
| **Legal**: No |
| None identified at this stage. |
| **Reputational**: Yes |
| Loss of accreditation would have significant reputational implications, for the Health Board and NHS Wales. |
| **Socio Economic**: Yes - *https://www.gov.wales/socio-economic-duty-guidance* |
| Loss of accreditation could result in patients having to travel significant distance for treatment with the potential that this has a disproportionate negative impact on certain patients/patient groups. |
| **Equality & Health**: Yes |
| An EHIA will need to be complete as options are developed to mitigate the risk of losing accreditation. Should the accreditation be lost an EHIA will need to be complete to consider the implications of this. |
| **Decarbonisation**: Yes |
| The outcome of the accreditation, as well as the mitigating actions may have an impact and will need to be fully assessed and considered. |
| **Welsh Language**: Yes |
| Loss of accreditation may mean that this services is no longer available in Wales and therefore in Welsh. |

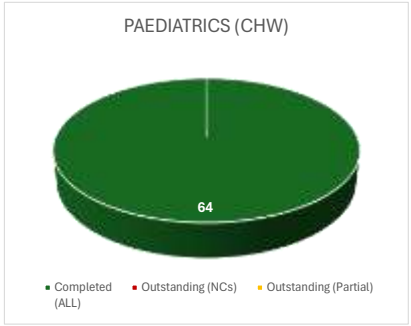
| Team | Issue | Action | Owner | Update July 2026 | Risk of Action Completion by Deadline |
|---|---|---|---|---|---|
| Paediatrics - clinical | The number of autologous HSCT procedures is below JACIE requirements. | Consider options for future delivery of service in light of issue. | Children & Women Clinical Board | SLT approved proposal to request derogation from service specification. Formal letter to be drafted to JCC following JACIE outcome. | |
| Paediatrics - collection | Number of bone marrow harvests below JACIE threshold | JACIE has suggested introducing simulation procedures or ceasing activity | Paediatric Lead/Apheresis Lead | Processes agreed and updated/relevant SOPs in place | |
| | Number of apheresis harvests insufficient to maintain competencies | Option to maintain apheresis competency by doing adult procedures | | | |
| Paediatrics - personnel | Single nurse capable of performing apheresis procedures (succession planning needed) | Consider paediatric nurses maintaining competencies on adult patients or alternatively adult nurses performing procedures on paediatric patients to improve robustness of cover | | | |
| Processing facility - personnel | Staffing levels in the processing facility are inadequate | CD&T to undertake gap analysis to address the deficits raised by JACIE | NWJCC | Internal mitigations in place pending approval of JCC revenue case. | |
| | Unable to provide on-call cover for LN2 storage tanks (also noted by HTA as a deficiency) | | | | |
| CVUHB Adult - premises | Inadequacy of adult facilities, specifically: | | Capital, estates & facilities; Clinical team | HDC extension ongoing. Delay in completion so additional support in place to review timelines and implications. | |
| | Haem Day Centre (adults) | Upgrade of HDC Adults in progress | | | |
| | Day Centre (TCT) | TCT-aged patients to use upgraded adult facilities until upgrade of TCT facilities | | | |
| | Inpatient facility on B4/C5 Haem | Capital scheme | | SOC submitted to WG, awaiting feedback. | |
| | Ambulatory Care | | | | |

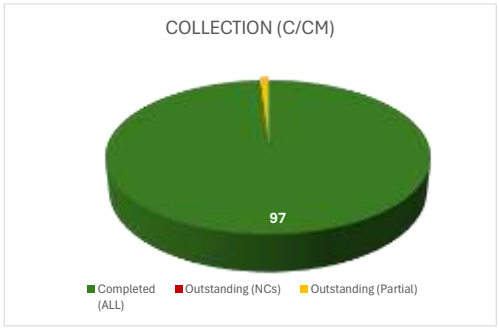
| | | | | | |
|---|---|---|---|---|---|
| | Outpatients | | | | |
| SBUHB - premises | The Autologous Transplant Service needs to expand in both space and workforce to manage current demand. | SBUHB developing a Business Case to address deficits | NWJCC | Revenue case Submitted to JCC, currently undergoing scrutiny review and awaiting feedback. Letter received advising of process and intention to include in IMTP 27/28 following scrutiny and agreement. | |
| SBUHB - personnel | The Autologous Transplant Programme requires a robust succession plan for potential Programme Directors and BMT Nursing Coordinators. | | | | |
| | The programme is heavily dependent on single CNS for smooth operation, highlighting the need for increased resilience. | | | | |
| | Expansion of nursing roles at Singleton is needed, in line with the role expansion at Cardiff | | | | |
| | The Nurse Educator role needs to be restructured to enable the post holder to deliver more effective transplant training to the nursing team. | | | | |
| | The pharmacist requires dedicated time for transplant related Continuing Professional Development (CPD). | | | | |
| | Notable differences exist between the two transplant programmes; Singleton patients do not have access to pre-habilitation or rehabilitation services, leading to inequities in patient care. | | | | |
| QA | Remaining non-compliant/partially compliant actions to be addressed by team | Quality team working through full standards spreadsheet, action owners assigned to each non or partially compliant standard | SWBMT Quality Team/Programme Director | Some delays in progressing actions due to capacity of clinical team – no significant concerns raised and expected to complete ahead of final deadline. | |
| | | Vacant posts in the Quality Team to be fast tracked for recruitment | | | |

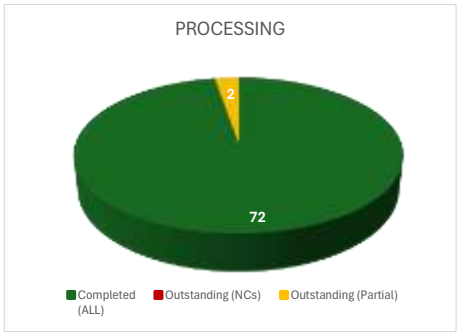
| ACTIONS | Total NC | Completed (NCs) | % NC COMPLETED | Total PC | TOTAL (ALL) | Completed (ALL) | Outstanding (ALL) | Outstanding (NCs) | Outstanding (Partial) | %ALL COMPLETED | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|
| CLINICAL (UHW) | 24 | 24 | 100% | 23 | 47 | 47 | 0 | 0 | 0 | 100% | *Training documents submitted to partial compliance (completion pending) |
| CLINICAL (SB) | 7 | 7 | 100% | 16 | 23 | 23 | 0 | 0 | 0 | 100% | *Training documents submitted to partial compliance (completion pending) |
| PAEDIATRICS (CHW) | 7 | 7 | 100% | 57 | 64 | 64 | 0 | 0 | 0 | 100% | *Training documents submitted to partial compliance (completion pending) |
| COLLECTION (C/CM) | 25 | 25 | 100% | 73 | 98 | 97 | 1 | 0 | 1 | 99% | * Validation plan for Paediatrics- contronics system, BM harvest procedures (WBS) |
| PROCESSING | 15 | 15 | 100% | 59 | 74 | 72 | 2 | 0 | 2 | 97% | * stability programme, alarm function will remain partial until Contronics implemented. Report regarding commitment for staffing (oncall) |
| QUALITY | 9 | 9 | 100% | 25 | 34 | 33 | 1 | 0 | 1 | 97% | *Contingency plan for storage (new facility)- to partial complaince, competency assessments (SB) |
| TOTAL | 87 | 87 | 100% | 253 | 340 | 336 | 4 | 0 | 4 | 99% | |




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

**Executive Headquarters / Pencadlys Gweithredol**

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Eich cyf/Your ref:
Ein cyf/Our ref: **SR-jtf-0726-259**
Welsh Health Telephone Network:
Direct Line/Llinell uniongychol: **029 2183 6011**

**Suzanne Rankin**
**Chief Executive**

7 July 2026

To: JACIE Accreditation Committee

Dear Colleagues

**Re: Re-submission – South Wales Blood and Marrow Transplant (SWBMT) Programme (ID 1390)**

We are writing on behalf of Cardiff and Vale University Health Board (CAVUHB), host organisation for the South Wales Blood and Marrow Transplant (SWBMT) Programme, in response to the JACIE inspection undertaken in September 2025.

The Health Board remains fully committed to maintaining JACIE accreditation and ensuring that the Programme continues to meet the high standards expected of a specialist transplant service. The findings of the inspection have been taken extremely seriously and have been subject to sustained executive oversight by the Health Board. Over the last six months, a structured improvement programme has delivered significant progress across estates, workforce, governance and service delivery. This work has been undertaken in close partnership with commissioners (NHS Wales Joint Commissioning Committee – NWJCC) and Welsh Government capital colleagues to ensure that the remaining actions are supported by agreed plans, clear delivery routes, and appropriate funding and approval processes.

**Governance and Programme Oversight**
A dedicated programme of work was established following receipt of the inspection report, with all actions allocated to accountable leads and monitored through formal governance arrangements. Progress has been subject to regular review through programme governance structures, Clinical Board oversight and Executive Team reporting, ensuring organisational ownership and timely escalation of issues where required and reflecting the Health Board's commitment to maintaining JACIE accreditation and ensuring the long-term sustainability of the service.

**Estates and Infrastructure**
The Health Board acknowledges the estate-related concerns raised during the inspection and has prioritised these within its capital planning processes.

Over the last six months:

- Building works have commenced for the expansion of the Adult Haematology Day Centre, which is expected to be completed by the end of 2026.
- A Strategic Outline Case (SOC) for a new-build inpatient, ambulatory care and outpatient facility has been developed, approved through Health Board governance processes and submitted to Welsh Government for consideration within the national capital programme.
- The development of the scheme and associated SOC has been undertaken in close collaboration with Welsh Government Capital colleagues, ensuring alignment with national capital planning requirements and providing a clear route through the approval process.
- A separate Strategic Outline Case is also being prepared to support the future upgrade of the existing stem cell processing facilities, recognising the importance of maintaining compliant and sustainable laboratory infrastructure.

Subject to Welsh Government review processes, an initial response to the SOC is anticipated in July 2026, following which the programme will progress through the established business case approval stages. Whilst these timescales are dependent upon national capital processes, all schemes have a defined route through the Welsh Government approval framework and continue to receive organisational support and oversight.

The Teenage Cancer Trust Day Centre cannot be brought into compliance within the existing estate footprint. As a mitigation, transplant patients requiring day-case treatment will be accommodated within the expanded Adult Haematology Day Centre on completion of the development.

**Workforce and Service Sustainability**
Workforce requirements identified through the inspection have been fully assessed and translated into a detailed staffing proposal.

Over the last six months:

- Workforce modelling and demand analysis have been completed.
- A business case for the required staffing establishment has been developed and approved internally.
- The proposal has been formally submitted to commissioners through established commissioning and planning processes.
- The workforce requirements and proposed staffing model have been developed in partnership with commissioners, who have been engaged throughout the process and recognise the importance of maintaining JACIE accreditation and supporting the long-term sustainability of the service.

The case is currently progressing through commissioner review, with responses anticipated in the next 4 weeks. Commissioners have advised that a proposal for additional funding will be included within the NWJCC prioritisation and planning process, to be conducted over the autumn 2026, as part of the development of the Integrated Medium-Term Plan 2027-30. We therefore anticipate a final decision around October 2026 with funding released for the start of the new

financial year. In parallel, the service has continued recruitment, succession planning, competency development, and quality support arrangements to mitigate immediate risks and maintain service resilience.

The Health Board has also committed to internally funding several key posts pending the outcome of commissioner funding processes, recognising the importance of maintaining progress towards full compliance.

**Paediatric Transplantation and Collection Services**
Following detailed consideration of JACIE standards and activity thresholds, the service has concluded that paediatric clinical transplantation activity does not currently meet the required minimum volumes.

We therefore request removal of paediatric clinical transplantation from the scope of accreditation. This represents a standards-compliant approach that aligns accreditation with sustainable service activity and ensures compliance is maintained within those services that can consistently meet JACIE requirements.

In addition, adult and paediatric collection services have been merged operationally to support maintenance of competence, strengthen workforce resilience, and ensure ongoing compliance with JACIE standards.

**Quality, Compliance and Risk Management**
Significant work has been undertaken to strengthen quality management arrangements, including review and updating policies, procedures, competency frameworks, and governance processes. All inspection actions continue to be monitored through a formal action tracker, with clear ownership, defined timescales and executive oversight.

**Conclusion**
The SWBMT Programme has responded to the inspection findings with urgency, transparency and strong organisational commitment. Over the last six months, substantial progress has been achieved, including commencement of the Haematology Day Centre expansion, submission of the Strategic Outline Case for future facilities, progression of workforce investment proposals through commissioner processes, strengthening of governance arrangements and implementation of service changes required to support compliance.

Whilst several actions remain dependent upon Welsh Government capital approvals and commissioner funding decisions, these are progressing through established pathways with clear timelines, regular oversight and ongoing engagement with both commissioners and Welsh Government colleagues. The Health Board is committed to working collaboratively with all partners to ensure successful delivery of the remaining actions required to achieve and maintain full compliance with JACIE standards.

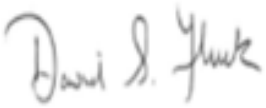
In the interim, the Health Board is progressing additional mitigations to support service resilience and compliance, including expansion of ambulatory care capacity and internal investment in key workforce posts where required.

We trust this update provides assurance that the findings of the inspection have been addressed robustly and that there is clear executive commitment to completing all remaining actions. Cardiff and Vale University Health Board remain fully committed to maintaining JACIE accreditation and supporting the continued delivery of a safe, sustainable and high-quality Blood and Marrow Transplant Programme for the population we serve.

We respectfully request that the Committee consider this evidence in support of reaccreditation of the SWBMT Programme, excluding paediatric clinical transplantation services as outlined above.

Yours sincerely

**Suzanne Rankin**
**Chief Executive**



**David Fluck**
**Medical Director**

| | | | | | |
|---|---|---|---|---|---|
| Report Title: *(needs to match agenda)* | Accessible standards and communication policy | | Agenda Item No: | | 8.1 |
| Meeting: | Quality Committee | Public | ☒ | Meeting Date: | 28 July 2026 |
| | | Private | | | |
| Lead Executive Title: | Executive Director of Nursing | | | | |
| Report Author/s Title: | Assistant Director of Patient Experience<br>Unpaid Carers and accessible standards lead | | | | |

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

**ALERT** *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

**ADVISE** *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

**ASSURE** *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

The policy promotes equitable access, patient safety, inclusive communication and compliance with statutory duties. It gives staff a clear framework for identifying and recording communication needs, making reasonable adjustments, and arranging qualified communication support. The completed Equality and Health Impact Assessment identifies an overall positive impact, with the main implementation risks relating to interpreter availability and the consistent recording and application of communication needs across services.

- The policy provides assurance that communication and information needs will be identified, recorded and made visible to staff at each point of contact.
- It confirms that staff should use qualified interpreting, translation and communication support services, particularly for sensitive, complex or consent-related discussions.
- It reduces the risk that communication barriers will affect patient understanding, consent, dignity, safety, experience or access to services.
- Successful implementation will depend on staff awareness, clear booking guidance, use of system alerts where available, and monitoring through the Accessible Standards Self-Assessment Tool.

**Board/Committee Response Required *(please select only one)***

*To confirm the action Members are being asked to take considering the AAA Framework*

| | | | | | |
|---|---|---|---|---|---|
| **Assurance** | | **Approval** | ☒ | **Information/Noting** | |

**Recommendations**

- APPROVE the Accessible Information and Communication Policy for implementation across Cardiff and Vale University Health Board.
- NOTE the completed Equality and Health Impact Assessment and the overall positive impact identified.
- NOTE the implementation actions relating to recording communication needs, staff access to interpretation and translation guidance, awareness raising, and monitoring through audit/self-assessment

| **Governance Route** ***(please list all other Committee/Groups this report has been to)*** | |
|---|---|
| ***Where*** *it's been:* | *Consultation process and stakeholder review* |
| ***When*** *it went:* | |
| ***What*** *decision was made:* | |

**Main Report**
*Background & Current Situation*

This report seeks Quality Committee approval of the Accessible Information and Communication Policy. The policy aims to support safe, equitable and person-centred care by ensuring that patients, service users, parents and unpaid carers can access services in a way that meets their communication and information needs.

The policy brings together the All-Wales Accessible Communication and Information Standards 2025, the UHB Interpretation and Translation Policy, and relevant duties under the Equality Act 2010. It sets organisational expectations for identifying, recording and responding to communication and information needs, including access to professional interpreting, translation and communication support.

The policy applies to people who are D/deaf, hard of hearing, British Sign Language users, deafblind, blind or visually impaired, neurodivergent, living with cognitive or learning disabilities or mental health conditions, have low literacy, or whose first language is not English or Welsh. It also applies to patients, parents and unpaid carers whose communication needs must be considered during care, appointments, referrals, discharge and handover.

**Appendices:**
*(List any appendices that will accompany this report).*

- Appendix 1: UHB 597 – Accessible Information and Communication Policy.
- Appendix 2: AIS Policy Equality and Health Impact Assessment V1.

**Strategic Alignment – Shaping Our Future Wellbeing:**

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

**Impact Assessment**

**Risk**: Yes

Risks relate mainly to inconsistent identification/recording of communication needs and interpreter availability. Mitigations include clear recording expectations, access to professional interpretation and translation services, staff awareness and monitoring through self-assessment/audit

**Safety**: Yes

The policy is intended to reduce safety risks linked to communication barriers, particularly around consent, results, medication information, sensitive discussions and discharge/handovers

**Financial**: No

No specific financial implications are identified in the supplied policy/EHIA documentation. The policy refers to use of existing interpretation, translation and communication support arrangements.
Adherence to the policy should effectively enable management and monitoring of translation costs

**Workforce**: Yes

| |
|---|
| There are workforce implications relating to staff awareness, consistent recording of needs, use of alerts where available and knowledge of how to access interpretation and translation services. |
| **Legal**: Yes |
| There are workforce implications relating to staff awareness, consistent recording of needs, use of alerts where available and knowledge of how to access interpretation and translation services. |
| **Reputational**: Yes |
| Inconsistent implementation could adversely affect patient confidence and experience. Approval and implementation of the policy provides assurance that the UHB has a clear organisational approach. |
| **Socio Economic**: Yes - *https://www.gov.wales/socio-economic-duty-guidance* |
| The policy supports people who may experience barriers linked to low literacy, deprivation, disability, language need or limited access to resources by promoting free accessible communication support. |
| **Equality & Health**: Yes |
| EHIA completed. It identifies an overall positive impact on equality and health outcomes and recommends ongoing monitoring and review. |
| **Decarbonisation**: No |
| No significant adverse decarbonisation impact has been identified in the documentation provided. The policy focuses on improving accessible communication and equitable access to care. Greater use of remote online translation may help reduce the carbon footprint associated with service delivery. |
| **Welsh Language**: Yes |
| *Applicable – LTP expectations include accessible communication and reasonable adjustments, supporting Welsh language needs.* The policy supports Welsh Language Standards through bilingual/public-facing information requirements and consideration of Welsh language communication needs. |

| | |
|---|---|
| **Reference Number:** *UHB 595*<br>**Version Number:** 1 *unless document for review* | **Date of Next Review:** *To be included when document approved*<br>**Previous Trust/LHB Reference Number:** *n/a* |

# ACCESSIBLE INFORMATION AND COMMUNICATION POLICY

## Policy Statement

This policy ensures that all patients, service users and unpaid carers can access safe, equitable, person-centred healthcare regardless of their communication or information needs.

It integrates the **All-Wales Accessible Communication & Information Standards** 2025 and the **UHBs Interpretation and Translation Policy**, and legal duties under the Equality Act 2010.Regulatory updates January 2024 to the act which strengthened the law on indirect discrimination and disability definition.

## Policy Commitment

The policy sets out clear standards across the organisation to promote good practice and minimise risks which stem from communication barriers and it covers the use of face to face, telephone interpreting and written translation services in accordance with identified need. Ensuring patients, unpaid carers and service users who have information or communication needs relating to, language needs, a disability, impairment or sensory loss receive accessible information and communications support such that they are not put at a substantial disadvantage.

This will be achieved by ensuring the following:

- Information and communication needs identified and recorded in the patient's paper and or electronic health records (in the designated communication needs/alert section where available) and clearly flagged so they are visible to all staff at every contact.
- Staff have access to qualified interpretation, translation and communication support services and are informed how to use these services.
- There are mechanisms in place for individuals to make a complaint, raise a concern or pass on feedback in alternative formats and with communication support.

## Supporting Procedures and Written Control Documents

This Policy and the *'supporting procedures'* describe the following with regard to Accessible Communication and Information:

- All Wales Accessible Communication and Information Standards 2025

- CAV Written Information for Patients Guidance
- Strategic Equality and Inclusion Plan 2024 - 2028
- Equality Act 2010

**Other supporting documents are:**

- *Welsh Language Standards Policy*
- *Strategic Equalities Objectives and Plan 2024-2028*

**Scope**

This policy applies to all of our staff in all locations including those with honorary contracts.
*For clarification on terms used below, please see definitions in Appendix 1*

Communication needs covered include:

- D/deaf, hard of hearing, British Sign Language (BSL) users, deafblind (including tactile BSL).
- Blind, visually impaired, braille/Moon users.
- Neurodivergence
- Cognitive, learning disabilities and Mental Health conditions
- Low literacy
- People whose first language is not English or Welsh.
- People requiring interpreters or translated materials.

The scope of the policy includes:

- communication, including methods available for people to contact the Health Board and support for patients, parents and unpaid carers, in appointments
- information, including all information published by the Health Board whether hard copy or electronic, including the accessibility of documents, online content, and the availability of information in accessible formats
- addressing communication needs, including arranging professional interpreting and adapting behaviour to support individuals or groups of patients
- support for communication needs for all patients, parents and unpaid carers whose first language is not English, including BSL and for Deaf/blind patients who use tactile BSL

| **Equality & Health Impact Assessment (EHIA)** | |
|---|---|
| Part 1 - Equality Impact Assessment (EQIA) | An Equality Impact Assessment (EqIA) has been completed and this found there to be a positive impact. Key actions have |

| | |
|---|---|
| | been identified and these can be found within Equality & Health Impact Assessment document<br>*Note: if an EqIA has not been completed indicate why* |
| Part 2 - Health Impact Assessment (HIA) | A Health Impact Assessment (HIA) has been completed and this found there to be a positive impact. Key actions have been identified and these can be found within Equality & Health Impact Assessment document<br>*Note: if a HIA has not been completed indicate why* |
| **Policy Approved by** | Quality and Safety Committee |
| **Group with authority to approve procedures written to explain how this policy will be implemented** | For example: Health System Management Board |
| **Accountable Executive or Clinical Board Director** | Angela Hughes, Assistant Director of Patient Experience |
| **Author** | Suzanne Becquer-Moreno, Carers Lead, Patient Experience |
| **Disclaimer**<br>**If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.** | |

| **Summary of reviews/amendments** | | | |
|---|---|---|---|
| **Version Number** | **Date Review Approved** | **Date Published** | **Summary of Amendments** |
| 1 | Date approved by Board/Committee/Sub Committee dd/mm/yyyy | TBA<br><br>*[To be inserted by the Gov. Dept]* | *State if either a new document, revised document (please list main amendments).*<br>*List title and reference number of any documents that may be superseded* |
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**Introduction:**

The aim of the Accessible Information and Communication policy is to provide appropriate, timely and effective assistance and support to people where the Health Boards usual methods of communication may disadvantage them. This policy applies to all areas of the Health Board to ensure that measures are in place to support communication needs for non-English speakers, people for whom English is a second language, people with reading or learning difficulties, people with learning disabilities, people with speech and language impairments, people with visual impairments and deaf people or people with hearing impairments.

This policy describes how the Health Board will ensure that patients and service users, unpaid carers and parents who have information or communication needs receive:

- **Accessible information** - information which can be read or received and understood by the individual or group for which it is intended.

- **Communication support** - support which is needed to enable effective, accurate dialogue between a professional and a service user to take place.

This ensures that the patient/service users are not put at a disadvantage when accessing Health Board services. This includes accessible information and communication support to enable individuals to:

- Make decisions about their health and wellbeing, and about their care and treatment.
- Self-manage conditions.
- Access services appropriately and independently.
- Make choices about treatments and procedures including the provision or withholding of consent.

The policy aims to support staff to provide accessible information and communication support and highlight why it is important. As well as defining the roles and responsibilities of staff with regards to accessible information and communication and providing advice about some of the more common information formats and communication support that may be needed.

Finally, it will detail the guidance in relation to local procedures associated with arranging and procuring interpretation, translation, transcription and other forms of communication support.

## Policy

It is the Health Board's responsibility to ensure that patients and service users, and their carers/parents who have information or communication needs relating to a disability, impairment or sensory loss receive accessible information and communications support, this will be achieved by ensuring that a patient communication and language needs are recorded on all relevant Clinical and Administration systems, i.e. PMS and PARIS, as well as implementing the following:

- appropriate interpreting service (telephone, face-to-face or online) is booked and provided to meet the individual's health and language needs, where practically possible.
- systems are in place to ensure that a standard print letter is not sent to an individual for whom this is not an appropriate or accessible format.
- processes are in place so that information about individuals' information and / or communication support needs is included as part of existing data-sharing processes, and as a routine part of referral, discharge and handover.
- Care plans include information about individuals' information and communication needs.
- Staff have access to communication (including decision making) tools and any relevant training to help them meet patients and service users' information and/or communication needs. Interpreter Booking Decision Pathway

It is key that Staff identify a person's language and/or communication need as soon as possible. This will enable staff who are responsible for arranging and booking interpreting and translation services to ensure that Health Board services are appropriately equipped and resourced to respond to individuals' needs.

Patients or their immediate family members/unpaid carers should be asked about their personal language preferences and this should be clearly highlighted within the patient's record. This should detail the service user's language and dialect requirements, as well as any additional communication needs.
**Please note:** Some languages such as Arabic and Kurdish have local dialectal differences, such as Kurdish Sorani or Kurdish Kurmanji, and the dialect is needed to ensure the correct interpreter is provided.

Additionally, any cultural needs should also be noted, any gender preferences, of interpreters, should be noted and acted upon where possible

For d/Deaf patients it is important to identify the person's preferred method of communication in advance of booking any support. For example, find out if they are a BSL user, lip reader or require written information in an accessible format, such as large print or Braille.

Once identified the staff should also note the most appropriate method of interpretation or translation support, such as telephone, face-to-face or video relay interpreting, lip reading/speaking, and so on. This may be recorded in the patient's paper or electronic record or detailed in the referral letter. If the preferred language/communication method is not stated, then tools to help identify the patients communication/language needs are available the Translation and Interpretation SharePoint pages Useful Documents

The language or communication support need should then be documented clearly in their records. This also includes recording any language support needs that family members or unpaid carers may have, so that the appropriate services can be booked for them. If a service user's first language is not English, but they state that they are able to communicate in English to a high standard and do not require an interpreter, respect their wishes for no language support to be provided. This should be checked regularly throughout the patient's admission.

Language and communication support needs should be enquired about on a regular basis and for future appointments in case preferences or needs change. It should also be noted that a person who might usually cope well with speaking English as a second language may find it more difficult to communicate effectively in stressful situations. Therefore, for more complex, challenging or sensitive appointments an interpreter for their primary language should be offered. In circumstances requiring consent or giving bad news an interpreter should also be provided.

For translation of written information and documents, staff should establish whether the best approach is to use an interpreter to read or sign information or whether to provide the information in an individual's first language – spoken or signed, or via a tactile writing method, such as Braille. It should be ascertained in advance that the patient can read their own language. Staff should be aware of how to access interpretation and translation services 24 hours a day, seven days a week. **Information and Support for this can be found on the** Translation and Interpretation SharePoint pages Translation & Interpretation Services - Home

All routine appointments should be made during core daytime hours and made in advance wherever possible.

It is acknowledged, however, that limitations to the provision of face-to-face interpreting services may occur, for example in emergency situations or rural areas, where there may be limited access to interpreters to enable face-to-face interpretation

For emergency appointments an interpreter should be provided as soon as possible, either by telephone, video relay or face-to-face depending on the service user's language need *"A breach of duty of care by members of the health care professions employed by NHS bodies or by others consequent on decisions or judgments made by members of those professions acting in their professional capacity in the course of employment, and which are admitted as negligent by the employer or are determined as such through the legal process."*

**Guidance on who can interpret for patients**

**Staff as Interpreters**

Staff who have not been trained to interpret, or who do not have interpreting as part of their role specification, should not be used as interpreters. There are three main exceptions to this:

- In an emergency/crisis situation where clear communication is needed immediately, and there is either no time to get an interpreter, or communication is needed whilst waiting for Scheduled Telephone Interpreting. In this situation, a bilingual member of staff who is present on site may be used but they must explain to the service user that they are not qualified interpreters. This will be documented in the patient notes why this approach was used, who provided the support, and what was discussed (at a high level) and that a professional interpreter was arranged/offered as soon as possible.

- It is acceptable for staff communicating basic information, such as, an appointment time, offering a choice for next appointment, or giving directions to a particular area or department, to act as an interpreter if they possess the knowledge of the appropriate language or communication skill.

- If speaking a particular language is part of the person specification for a role and the staff member is employed to speak that language, then

this isn't classed as interpreting as they will be speaking directly to their client in their chosen language as part of their role.

**Children as Interpreters**

This approach is informed by statutory duties under the **Equality Act 2010**, the **common-law duty of care**, and the safeguarding framework established by the **Social Services and Well-being (Wales) Act 2014**. NHS bodies must take reasonable steps to ensure effective communication, support valid consent, and protect children and adults from harm. National safeguarding and NHS guidance therefore strongly discourage the use of children as interpreters, except in rare, time-critical emergencies to obtain basic information necessary to protect life or immediate safety. Any such exceptional use must be proportionate, strictly limited, and clearly documented in the patient record.

Children should not be used as Interpreters. If a service user brings a child under the age of 16 to interpret, they should be discouraged from interpreting and a choice of a professional interpreter offered. The service user should be aware at all times that they can have an interpreter.

In the case of acute emergencies, healthcare professionals could use an accompanying child to elicit and communicate basic information, for example "What happened?" or "How did you get here?" or any necessary demographic information, such as "Who are you and where do you live?"

Most parents or carers will not discuss problems or worries in front of their children. Interpreting serious problems may traumatise children and, in many cases, using a child to interpret could upset a family's social order. If a patient insists on a child interpreting or translating, then this must be documented in the patient's notes.

**Use of relatives, friends, or carers for interpreting**

Relatives and friends should not be encouraged to interpret. The patient should be aware at all times that they can have the support of a skilled and professional Interpreter provided by the Health Board. It should also be remembered that while some friends and relatives may be able to help with the interpreting, this could be distorted, due to a particular concern, bias or conflicting interests. This may not be beneficial to the imparting of confidential information, whereas an independent interpreter is qualified and trained to maintain and respect confidentiality.

Health professionals should be aware that although relatives and friends may speak the same language, they might not be skilled or competent enough to interpret in a health care setting. If a patient insists on using friends or relatives for interpreting, then this must be documented in the notes. In cases where the patient clearly has concerns about using an interpreter, and would prefer to use family or friends, the health professional may need to work with them to understand more about why they don't wish to make use of this service, and be able to discuss the benefits and reasons for using qualified interpreters as stated above.

**Use of other clients or patients for interpreting**

It is unacceptable to ask other patients or clients to help with interpreting, for similar reasons to the ones stated above. The Health Board recognises that the use of an unskilled person to interpret is highly inappropriate and may lead to risk of misunderstanding, resulting in the intervention of inappropriate care or treatment.

**Service user's own choice of interpreter**

The Health Board cannot prevent a patient from bringing in their own choice of interpreter, instead of using the preferred provider, but the Health Board cannot be held responsible for the quality of interpreting and will not pay for this service.

**What to do if an Interpreter is refused**

If a patient is refusing to use an interpreter provided by the Health Board, and this results in the staff member feeling that this will actually prevent them from providing quality, safe and effective care, then the staff member may state that they don't feel that they can continue with their appointment or assessment on that occasion. This should be recorded in the case notes with reasons for this clinical decision.

**Use of Advocates** Staff should be aware that there is a distinct difference between providing an interpreting service and an advocacy service, but that these roles may sometimes overlap. If an advocate is provided, then it is the responsibility of the Advocacy service to provide their own suitably trained interpreter.

**Support for sensitive, vulnerable or traumatic appointments**

All interpreters of both spoken and sign languages should be aware of the potentially sensitive and emotive situations that they may encounter and should have appropriate support structures in place in case of the need to debrief or seek appropriate counselling (following interpreting for a vulnerable or sensitive case, such as a child, victim of violence, asylum seeker, and so on). NHS staff should also be aware of and considerate of situations of a sensitive or vulnerable nature (such as cases involving migrants, refugees or asylum seekers, or violent or abusive cases) which may require additional emotional support for patients, family members, clinicians and interpreters who are subject to hearing and interpreting sensitive and vulnerable information.

**Accessible Information Requirements**
**Documents & Written Information**
publication such as annual reports and patient information leaflets should be assessed on an individual basis and apply the following principles:

- Use a clear and easy to read font such as Arial.
- Use a minimum font size (point size) of 12.
- Keep sentences short – this means an average sentence length should be approximately 15- 20 words.
- Patient education materials should be produced in accordance with CAV Written Information for Patients Guidance (Link to guidance here)
- Simplify the language and make it appropriate for the reader, use Easy Read principles.
- Documents must follow accessible design: structure, headings, plain language,
- Public facing documents should be Welsh Language Act compliant.
- Avoid image-only PDFs when sending documents electronically; provide HTML/Word alternatives.

Patient letters including appointment letters, results and medication information must use a minimum font size of 12 and include:

Two of the following methods of communication:

- Phone number (with accessibility options if available)
- Email address
- Postal address
- Text/SMS
- An option to request in a format to meet the patient's communication need (i.e. large print, braille)

**Accessible Standards Self-Assessment**

All departments are required to complete the Accessible Standards Self-Assessment Tool which will be available universally across the Health Board on the recommended Audit tool Platform. The Self-Assessment is designed to help teams assess how well they are meeting patients, parents and unpaid carers communication needs within their services, in line with the All-Wales Communication and Information Standards.

**Appendix 1**

**Definitions:**

**Braille -** A tactile reading and writing system used by people who are blind, Deafblind and visually impaired who cannot access print materials. It uses raised dots to represent the letters of the print alphabet. It also includes symbols to represent punctuation, mathematics and scientific characters, music, computer notation and community languages.

**British Sign Language (BSL)** - The first, only, or preferred language of many people who are D/deaf. It is a registered language in its own right, with its own grammar and syntax. It is a visual-gestural language which bears little resemblance to English.

**Communication tool / communication aid:** - A tool, device or document used to support effective communication with a disabled person. They may be generic or specific / bespoke to an individual.

**Example of Communication Support Aids**

- Hearing loops
- Makaton and symbol-based supports
- Communication devices
- BSL Videos

**d/Deaf** - A person who identifies as being deaf with a lowercase d is indicating that they have a significant hearing impairment.

**Deafblind guide/communicator -** A professional communicator who enables communication between Deafblind people and others. Different skills and techniques can be used to facilitate communication, including Deafblind manual or hands-on signing (tactile BSL). In their role as a guide, they will also escort dual-sensory impaired people from their homes to the Deafblind person's destination of choice. They can also provide support during an appointment by taking notes if necessary

**Deafblind manual alphabet -** Using the index finger as a 'pen' the guide/communicator points to different finger positions on the Deafblind person's hand or draws letter shapes on the Deafblind person's palm.

**Deafblindness or dual sensory impairment –** People who are Deafblind can neither see nor hear, to the extent that their communication, mobility and access to information is significantly impaired. Some Deafblind people have enough sight to use BSL interpreters, whereas others do not and use tactile or manual sign.

**Electronic and manual note takers** - These work with people who are D/deaf or hard of hearing, who are comfortable reading English. The electronic note taker types a summary of what is being said on a computer and this information appears on the D/deaf person's screen. BSL interpretation should therefore be used.

**Finger spelling -** This is a system where all letters of the English alphabet can be drawn on the hands. It is also known as the manual alphabet. Finger spelling is used by some BSL users to aid understanding by spelling the names of people and places which might be unfamiliar.

**Interpretation/Interpreter** - the facilitation of spoken, British Sign Language (BSL), Video Relay Service (VRS), lip speaking, note taking, and tactile BSL - not just the meaning of the individual words, but the essence of the meaning too.

**Lip speaking/reading -** Lip speakers repeat what is being said without using their voice. They produce the shape of words clearly with the flow, rhythm and 56 phrasing of speech. They use natural gestures and facial expressions to help the person who is lip reading to follow what is being said.

**Makaton** - A language programme that uses symbols, signs and speech to enable people to communicate. This programme is used with people with a cognitive impairment or specific language impairment including neurological disorders. It includes manual signs and graphic symbols so is used for communication support as well as written information.

**Moon** - The Moon system of embossed reading is a writing system for the blind. The Moon alphabet has embossed shapes which can be read by touch. Some of the Moon letters resemble the letters of the Latin alphabet, or other simplified letters or shapes. The Moon alphabet is easier to learn than Braille, particularly for people who lose their sight later in life.

**Remote/online interpreting/Video Relay Service (VRS):** Video interpretation uses a face-to-face interpreter in a fixed geographical point accessed through video technology. The service requires a camera and mic

on the receiving device, such as a computer, tablet or phone. It can be used for spoken languages as well as sign language.

**Tactile BSL** - This is used by people who are Deafblind. It is a form of British Sign Language that uses touch (hands-on) as a medium to communicate.
**Transcription:** The process of producing a written copy of something, including the representations of speech or signing in written form.

**Translation:** The written transmission of meaning from one language to another that is easily understood by the reader. Translation does not strictly have to be into text – this also includes the conversion of written information into audio, Braille or Moon, or the production of visual formats to transfer information using British Sign Language (BSL). Translation of documents can include the reading to the patient of a letter (or source of information) into the language required by the patient – known as sight translation