Public Quality Committee
30th June 2026
09:00 via MS Teams
Public Agenda

1. 09:00	**Standing Items**	**Assurance Approval Noting/Info**	**Lead**
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. 09:05	**Quality Performance Reporting**		
2.1 *5 mins*	Quality Performance Report – verbal update	Assurance	Alex Scott
3. 09:10	**Items for Oversight / Scrutiny**		
3.1 *30 mins*	Clinical Board Highlight Reports: • *3.1.1 - Medicine CB* • *3.1.2 - Surgery CB* • *3.1.3 - Children & Women CB* • *3.1.4 - PCIC CB* • *3.1.5 - CD&T CB* • *3.1.6 - Specialist Services CB* • *3.1.7 - Mental Health CB* *Some of the above reports have minutes included as an appendix. These are in the supporting documents folder*	Assurance	Execs
3.2 *10 mins*	Annual Reports: • *3.2.1 - Complaints, Redress and Inquests*	Noting	Angela Hughes
3.3 *5 mins*	Quality & Operational Risks (scoring 20 – 25)	Assurance	Matt Phillips
4. 09:55	**Strategy: Providing Outstanding Quality**		
4.1 *5 mins*	Board Assurance Framework	Assurance	Matt Phillips
5. 10:00	**Shaping our Population Health and Place-Based Partnerships:**		
	No items		
6. 10:00	**Shaping our Quality, Value & Sustainability**		
6.1 *10 mins*	*Update on Fuller Report recommendations*	Assurance	Helen Luton / Scott Gable
7. 10:10	**Shaping our Future Clinical Services**		

7.1 *10 mins*	*Cardiac Implant Update*	Assurance	David Hanna Peter O'Callaghan
7.2 *15 mins*	*Ophthalmology review update*	Assurance	Clare Wade
8. **10:35**	**Policies for Approval**		
	No policies for approval.		
9. **10:35**	**Items for Noting / Information**		
9.1 *5 mins*	Safeguarding Steering Group (SSG) Minutes *Located in the supporting documents folder*	Assurance	Jason Roberts
9.2 *5 mins*	Infection Prevention & Control (IPC) Group Minutes *Located in the supporting documents folder*	Assurance	Jason Roberts
10. **10:45**	**Are there any items from the meeting that require escalation to Board?**		
11. **10:45**	***Private Meeting Business:*** ***1. Minutes from previous meeting*** ***2. Any Urgent / Emerging Themes*** ***3. Annual Quality Report***		
12.	**Any Other Business**		
13.	**Review of the Meeting**		
14.	**Date & Time of Next Meeting:** *28th July 2026 via MS Teams*		

Draft Minutes of the Public Quality Committee

Held on 2nd June 2026 via MS Teams

To view the meeting: https://youtu.be/OAu9zSp2tvE

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Judi Rhys	JRH	Independent Member – Third Sector
Rachna Upadhya	RU	Independent Member - General
Kirsty Williams	KW	UHB Chair
In Attendance		
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Natasha Goswell	NG	Deputy Executive Nurse Director
Angela Hughes	AH	Assistant Director of Patient Experience
Matt Phillips	MP	Director of Corporate Governance
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
Claire Beynon	CB	Executive Director of Public Health
Catherine Wood	CW	Deputy Chief Operating Officer
Additional Attendees		
Michael Allum	MA	Consultant in Public Health
Jessica Castle	JC	Director of Operations – Specialist Services Clinical Board
Abigail Holmes	AH	Clinical Board Director for Children & Women
Pamela Johnston	PJ	Independent Advisor – NHS Performance & Improvement
Natalie Vanderlinden	NV	Designated Education Clinical Lead Officer
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Paul Bostock	PB	Chief Operating Officer
Lauranne Cullen	LC	Regional Director for Llais
David Fluck	DF	Executive Medical Director
Suzanne Rankin	SR	Chief Executive Officer
Stephen Riley	SR	Independent Member – University

QC 2026/06/1.1	**Welcomes, Introductions & Apologies** Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh. Apologies for absence were noted.	ACTION
QC 2026/06/1.2	**Declarations of Interest** No declarations of interest were raised.	
QC	**Minutes of the Committee meeting held on 14.04.2026**	

2026/06/1.3	The minutes of the Committee meeting held on 14.04.2026 were received. **The Committee resolved that:** a) The minutes of the meeting held on 14.04.2026 were approved as a true and accurate record of the meeting.	
QC 2026/06/1.4	**Action Log following the Meeting held on 14.04.2026** The Action Log following the Meeting held on 14.04.2026 was received and discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 14.04.2026 was noted.	
QC 2026/06/1.5	**Committee Chair's Actions** No Chair's Actions were raised.	
	Quality Performance Reporting	
QC 2026/06/2.1	**Quality Performance Report** Alexandra Scott (AS), the Assistant Director of Quality and Patient Safety, presented an overview of the development of a new Integrated Performance Report (IPR), replacing the existing quality indicators report. AS summarised the following: • The revised approach would use statistical process control (SPC) charts to better identify trends, variation, and the impact of improvement activity, which supported more robust assurance. • The Standardised IPR would provide a single, consistent source of performance and quality information across the organisation, reduce duplication and improve alignment across Committees. • Phase 1 would focus on statutory and nationally required indicators (including performance, quality & safety, and equity measures), with initial reporting expected by July 2026. • Phase 2 would expand the report to include more detailed and outcome-focused indicators aligned to organisational priorities and the Shaping our Future of Quality Excellence (SOFQE) Programme. • Further work was needed to agree how the report would be used by the Committee. Claire Beynon (CB), the Executive Director of Public Health, noted that the suitability of the proposed methodology depended on the frequency of data collection, and emphasised the importance of applying the approach selectivity and appropriately. Kirsty Williams (KW), the UHB Chair, asked whether they had the capacity, capability and data to deliver this ambition, and what the key risks were. AS responded with the below: • Phase 1 would standardise reporting of existing quality indicators to improve clarity and support more informed discussions • Phase 2 involved wider organisational engagement with colleagues to identify additional indicators that provided stronger assurance and supported improvement, rather than being limited by current data availability.	

	Vicki Burrell (VB), the Senior Service Improvement Programme Manager, explained that several measures were already within existing SOFQE Programme workstreams, but there were ongoing challenges regarding the availability and reliability of data. KW expressed concern regarding data gaps limiting assurance. KW asked when Phase 1 would end and Phase two would start. AS responded that Phase 1 was expected to be largely complete and operational by July, with Phase 2 indicators to be developed and in use by November/December. JR responded that this was an ongoing process to improve how quality was communicated across the organisation. Positives included a consistent template, improved trend analysis, and integration of equity into the quality agenda. Key concerns related to ensuring data was accurate, consistent, and standardised. Capability to support this would be developed through the Quality Management System (QMS). Judi Rhys (JR-IM), the Independent Member – Third Sector, asked what progress would be expected at upcoming Quality Committees, how this would be monitored for accountability, and how it would ultimately contribute to improving quality. AS responded that Phase 1 would be presented in July's Quality Committee, alongside proposals for developing Phase 2 quality indicators to ensure oversight and alignment with improvement goals. This would remain an ongoing programme, requiring collaboration with individual teams to define meaningful measures. CB explained that their vision in the strategy was for unfair differences in health outcomes to reduce. An internal audit had therefore been commissioned to assess the organisation's ability to collect protected characteristics data, with a subsequent focus on ensuring services used this data to identify and address inequalities. Rachna Upadhya (RU), the Independent Member – General), asked whether they could include an assessment of data quality (such as frequency of collection and confidence levels), so they could better judge accuracy, identify gaps and avoid false assurance. AS agreed the inclusion of confidence levels in the IPR would strengthen the interpretation of indicators. Phase 1 focused on indicators with robust data, whilst acknowledging areas needing improvement, for example clinical coding. Catherine Wood (CW), the Deputy Chief Operating Officer, provided assurance that a robust improvement plan was in place around clinical coding. **The Committee resolved that:** A) The Quality Performance Report was noted for assurance.	
	Strategic Portfolio: <u>Providing Outstanding Quality</u>	
QC 2026/06/3.1	**Board Assurance Framework (BAF)** Matt Phillips (MP), the Director of Corporate Governance, highlighted the following: • The BAF aligned organisational strategic objectives with Board-defined risk themes. • Feedback from the UHB Board meeting at the end of May 2026 had since been incorporated and shared with Executive leads. • Risk summaries had been streamlined from a detailed document into concise statements to improve clarity and usability at Board level. • The key strategic risks for this Quality Committee were:	

	○ i) Quality - there is a risk that workforce, digital, capacity and estate constraints, combined with weak escalation and organisational learning, lead to inconsistent and unsafe care, resulting in avoidable harm, poorer patient outcomes, long waits, reduced patient experience and diminished public trust ○ Health equity - There is a risk that insufficient investment in prevention, worsening socio-economic determinants, inequitable access and poor data limit the Health Board's ability to address inequalities, resulting in widened life expectancy gaps, higher morbidity in deprived populations and increased long-term demand on services • The Committee should use the BAF as an oversight tool and request deep dives on relevant risk areas. Future Board discussions were expected to focus increasingly on mitigations rather than risk identification • Work was underway to align the centralised risk register to strategic risk themes • Further development was planned to link intelligence from Clinical Boards, clinical safety groups and organisational datasets into Committee-level oversight KW noted concern regarding how effectively the BAF demonstrated gap closure and tracked progress over time. Additionally, KW suggested the need to strengthen linkages between the BAF and the corporate risk register. MP emphasised that the BAF should set the strategic context, with its value realised through Committee discussions and the agenda in driving action and assurance. MP supported using strategic risk themes to filter and escalate relevant risks to Committee level, supported by prior scrutiny (e.g. at Clinical Safety Groups). CB suggested reviewing the health equity strategic risk alongside the biannual Equity, Equality, Experience and Patient Safety Framework update, with a focus on gap assurance. CB also suggested periodic deep dives into other BAF risks, particularly quality, linked to relevant agenda items to support focused scrutiny. CP suggested retaining the BAF item on the agenda whilst discussions were ongoing. **The Committee resolved that:** A) The contents of the 2 Quality Committee aligned strategic risks – Quality and Health Equity – were noted; B) How the Committee wished to receive and use the BAF within the architecture of the new Committee format was discussed.	
QC 2026/06/3.2	**Shaping our Population Health and Place-Based Partnerships** 3.2.1 - Update for Women's Health Hubs Michael Allum (MA), a Consultant in Public Health, provided the following summary to the Committee: • The purpose of the report was to provide assurance that the UHB was delivering against the Women's Health Plan from Welsh Government (WG). • The Women's Health Hub was was a primary care cluster-based model established in Cardiff East, and began seeing patients in February 2026, and provided menopause care alongside a wider holistic offer. • The Hub continued in the current financial year due to cluster funding, which enabled evaluation of impact and sustainability	

	• Wider progress had been made across the Women's Health Plan, supporting long-term service development and strong engagement across the UHB • Work was ongoing to expand hub provision geographically and develop additional services in line with WG requirements • A minor report amendment was noted – further development areas also included postnatal health and healthy ageing. JR-IM asked how they were involving the Third Sector. MA responded that the Cardiff Third Sector Council (C3SC) were represented in the Steering Group. Additionally, they used some of the non-recurrent funding to resource and provide engagement and coproduction, with involvement continuing into this year. Angela Hughes (AH), the Assistant Director of Patient Experience, noted this aligned with current complaints themes, particularly around contraception services. AH offered to share complaint data to support further discussions. KW highlighted the ned to view women's health more broadly beyond gynaecology and reproductive care. KW sought clarity on sustainability plans given the reliance on non-recurrent WG funding, and how services would be maintained if the funding ceased. MA responded with the following: • Women's health extended beyond reproductive care, although the initial focus from WG had been on menopause, menstrual health and contraception • The sustainability risk from non-recurrent funding was recognised and was reflected in the risk register. They aimed at building sustainable, system-wide service change rather than short-term, standalone services. For example, a Health Needs Assessment was underway to identify gaps and inform future service design, including sexual health • There was strong engagement with primary care and cluster leads to support delivery within existing resources • The Steering Group was planning based on no ongoing additional funding and aimed to embed changes within current capacity. CB confirmed the programme focused on reducing health inequalities for women, with sustainability supported through lasting elements such as training in primary care, which would continue beyond the initial funding period. JR asked whether future focus was on expanding additional Hubs or embedding the hub model and principles across the whole organisation. JR emphasised the need for a system-wide approach to women's health inequalities beyond isolated services. MA confirmed that the preferred approach was to embed women's health principles across the organisation, with hubs acting as one tool to address inequalities. Further hub expansion was expected, but only where appropriate and sustainable for specific populations. The hubs formed part of a wider suite of interventions. RU asked how the Committee would see the impact of the Hubs on reducing secondary referral rates going forward. MA responded that monitoring of referral impact was being explored locally through analysis of the current Hub, with wider work underway at a national level to develop a women's health data dashboard. MA acknowledged the complexity in attributing	

	changes in referral rates to the Hub alone. It was confirmed that this was a developing area, with plans to provide updates and relevant data in the future. CP asked to what extent did the current data support analysis of equity and related considerations. MA responded that data was collected directly from practice systems, which included key equity characteristics such as age, ethnicity and deprivation. Whilst volumes were currently small, the dataset should support identification of inequalities over time, with ongoing reporting planned as the model developed. **The Committee resolved that:** a) The update in the Health Board's delivery of the Women's Health Plan for Wales over the last 6 months was acknowledged.	
QC 2026/06/3.3	**Shaping our Quality, Value & Sustainability** 3.3.1 - Quality Management System (QMS) Improvement Plan Natasha Goswell (NG), the Deputy Executive Nursing Director, provided the following summary to the Committee: • The QMS position statement was approved by Board in March 2026 and submitted to NHS P&I. • The purpose of the report was to outline the ambition for a single organisation-wide QMS, assess current maturity, and define priorities for the next 12 months. • The aim was to embed a joined-up, consistent approach to manage quality across planning, improvement, assurance and control. • There were four key components: 1. Quality Planning – embedding quality aims and measures into service design 2. Quality Improvement – strengthening capability to identify priorities, test changes and measure impact 3. Quality Assurance – improving triangulated, forward-looking assurance rather than increasing the volume of reporting 4. Quality Control – ensuring standards, audit and learning processes are proportionate and aligned to improvement. • Enablers included leadership, culture, governance, workforce capability and access to good date • Current maturity was assessed as "emerging to developing" maturity, with strengths in commitment but a need for greater consistency and reduced duplication • Key priorities for the next 12 months included establishing a clear QMS framework, strengthen quality planning and improvement capability, enhance assurance and intelligence, and align quality control processes CB asked for assurance that the 'equitable' dimension of quality was clearly embedded within the framework. NG responded that the four components of the QMS were underpinned by their duty of quality. Through indicators and the Clinical Governance framework, it aimed to ensure a "floor-to-board" view, embedding equity in both design and presentation. RU asked whether there was an estimate of quality failures from the past 12-18 months that could have been identified earlier if QMS was fully embedded, to help clarify the improvements expected going forward.	

	NG responded that to was difficult to know, but the main gap was clear “floor-to-board" visibility and assurance. Over the following 12 months, QMS would strengthen this and embed all four components to provide a clearer, more visible “golden thread” to demonstrate improvement and support assurance. RU asked what the greatest risk was to fully embed the QMS over the following 12 months, and what the Committee should be most vigilant about. NG responded that the baseline maturity matrix assessments would show their current position and key gaps to address for full embedding. As work progressed, further updates would come to the Committee to outline developments, identified gaps, and actions being taken. JR emphasised that it must be embedded in everyday practice. Success was defined as staff understanding the QMS and its impact on identifying, monitoring, and reporting risk. KW requested greater detail on the delivery plan and sought clarity on the key implementation risks. KW emphasised the need to demonstrate improved patient outcomes and suggested a potential deep dive to test delivery against the ambition. KW and CP suggested NG attend the Independent Members information session that week to follow up on some of these points. NG responded that a detailed QMS project plan existed but was not presented in full to this Committee. This could be reviewed separately and invited Committee members to attend project meetings for further insight. **The Committee resolved that:** a) The content of the development plan was noted; b) The Quality Management System Organisational Development Plan was approved; c) The approval of the QMS Organisational Development Plan was recommended to Board for approval prior to submission to NHS Performance & Improvement	
QC 2026/06/3.4	**Shaping our Future Clinical Services** 3.4.1 - Theatres Together Programme CW provided the following summary to the Committee: • The report aimed to assure sustained progress across all workstreams under the Theatres Together Programme, moving towards embedded cultural and operational improvements • 34 of the 66 recommendations had been completed, with ongoing progress across remaining areas. • The cultural survey had been undertaken in the perioperative team, and showed improved staff confidence, safety, and pride in theatre environments. Key improvement areas included communication across teams, visible feedback loops, and infrastructure, IT and estates. • In January 2026, the ownership of the Hospital Sterilisation and Decontamination Unit (HSDU) improvement plan had been integrated into the Theatres Together workstream, with 10 recommendations completed, 12 in progress, and 1 descoped.	

	• Workforce indicators were improving, which included reduced turnover, stable staffing, increased appraisals and training • Regarding Nationally Reportable Incidents (NRIs), some variability remained in incident reporting intervals, but trends suggested improvement • Data indicated more focus was needed on areas such as post-operative wound infection and complications of anaesthesia • The plan was to bring data to all relevant Committees to include clearer trajectory data and use of statistical process control to demonstrate sustained improvement. **For an update on progress against the Theatres Together Improvement Plan to return to a future Quality Committee – ACTION**. CB asked for more detail on the action which was descoped. **For further detail on the descoped action within the Theatres Together Improvement Plan to be circulated outside of the Committee – ACTION.** KW noted that they had not received theatre performance data since January 2026 which limited visibility on utilisation, timeliness and cancellations. KW asked when this data issue would be resolved. **Confirm timeline for restoring theatre performance data reporting – ACTION.** **The Committee resolved that:** a) The updates on the Theatre Together Programme were noted. 3.4.2 - Pathway to Safer Beginnings (Wales): Gap Analysis and Proposed Three-Year Improvement Programme Abigail Holmes (AH), the Clinical Board Director for Children & Women, highlighted the following to the Committee: • The language around maternity services had changed – the National MatNeo Safety Support Programme had disbanded, which had aligned to England. During the end of 2025, an independent assessment was commissioned by WG, and the outcome was the Pathway to Safer Beginnings for Perinatal Services across Wales. The paper aimed to provide a credible and aligned response to the Safer Pathways. • A three-year national programme of work would start soon, with recruitment ongoing. CAVUHB would develop their own three-year programme to align with the national work. • The assessment against the recommendations showed strong assurance in most of the eight areas, but not yet fully compliant. This required ongoing review rather than one-off reporting. • The five key gap themes included workforce capacity and sustainability, theatres and neonatal resilience, perinatal mental health provision, incident response and family involvement, and data inequalities. • Governance arrangements were strong but were still developing, particularly within the new perinatal structure. There was a need for a single, integrated dashboard which aligned clinical and patient-reported outcomes • There was a variability in the quality of care (e.g. birth reflections) and a requirement to maintain UNICEF Baby Friendly accreditation • Major risks included workforce skill mix, rising sickness, estates challenges, and gaps in mental health provision.	

	• Positive practice included bereavement and support services and strong family engagement. The model was to be scaled nationally. • There needed to be a national reconfiguration of the cots whereby CAVUHB would need to increase to 37 cots. However, this was dependent on other organisations taking down their cop base and had to led by the Joint Commissioning Committee (JCC). Until they could reconfigure their services, they would still encounter babies born in the wrong facility. • They needed to strengthen family involvement in investigations and service design • The Safe Beginnings Programme Board were to oversee delivery, with regular monitoring and a biannual gap analysis. JR noted that the recommendations were largely expected, and this was the first baseline gap analysis. AH would lead implementation, supported by existing governance within the Clinical Board. Progress would be held to account through Executive oversight and future updates could be brought through the Committee. RU requested timelines for completing the mapping of perinatal mental health services, and for further detail on impact (e.g. waiting times, staff training). AH responded that the mapping was expected to be completed within 1-2 months. The baseline understanding was already in place and gaps identified (e.g. a wellbeing midwife). The plan was to train all community midwives in trauma-informed care, with the Elan team (who look after more vulnerable women in the community) to be trained in the more advanced care. AH suggested the work feed into the Safer Beginnings Board, with quarterly updates then submitted to this Committee. CB asked whether the feedback-to-improvement pipeline was inclusive and captured diverse voices, rather than a single feedback loop. AH confirmed multiple feedback access points would be used. This included engagement through the Elan team and midwives supporting vulnerable women, alongside multilingual birth discussion groups to ensure inclusion of non-English speaking families. JR-IM asked whether third sector partners were engaged in supporting this work. AH confirmed there was strong engagement with the third sector, led by the consultant midwife for public health and vulnerable women, who had lots of close links with the third sector. KW asked how the UHB's senior leadership could influence national discussions and issues, and better support operational delivery. AH responded that the current Birthrate Plus workforce tool was not fit for purpose but remained mandated by WG. This failed to reflect the growing complexity and acuity in maternity and neonatal care. There was a need for a multidisciplinary workforce model to cover all roles, not just midwives. The ask of the Executive team was for them to help influence discussions to adopt or develop a better system (e.g. the Scottish model). JR confirmed that Birthrate Plus was being escalated via Executive Directors of Nursing (EDONs) to the Chief Nursing Officer. Work was underway to develop a more realistic approach to assess maternity workforce acuity in Wales.	

The Committee resolved that:

a) The work towards full implementation of the Pathways to Safer Beginnings Priorities was noted.

3.4.3 - JACIE Inspection Update

Jess Castle (JC), the Director of Operations – Specialist Services Clinical Board, highlighted the following to the Committee:

- JACIE accreditation had been deferred following inspection, with a response due by 8th July 2026 to address the 89 non-compliant areas (from around 2,300 standards)
- Actions were tracked via a Task & Finish Group, with confidence that priorities would be delivered in time despite some delays
- Outcome data was requested after the previous Quality Committee meeting – autologous transplant outcomes benchmarked strongly (five-year survival for entire cohort of autologous patients was 78% vs 73% for the rest of the British Society data, and five-year survival for the multiple myeloma patient cohort was 83% vs 73% for the rest of the Blood and Marrow Transplant programme). Allogeneic transplant outcomes were comparable to benchmarks despite being a more complex patient cohort.
- Key focus areas included estates upgrades to adult's facilities on the University Hospital of Wales (UHW) site, e.g. the extension to the haematology day unit was underway and due to be completed by November, and the business case for the inpatient and ambulatory facilities was being finalised to be submitted to WG. The Children & Women Clinical Board had prepared an options appraisal around the clinical programme for Paediatrics, which was due to be discussed in a Senior Leadership Team (SLT) meeting.
- Workforce challenges, primarily around the Swansea Bay UHB programme and the stem cell processing unit in CAVUHB, were being addressed through a business case submitted for to the JCC
- Next steps included the submissions to the JCC and WG, SLT consideration of paediatrics appraisals, and final accreditation response by 8th July, alongside continued work on outstanding actions.

RU asked for timelines for completing 19 outstanding clinical outcome data actions.

JC responded that the programme team confirmed they were on track to meet the submission deadline. A detailed tracker was in place, with some actions covering multiple requirements.

KW noted this was a risky position if they were not to be reaccredited, and asked what steps were being taken to address this.

JC responded that if reaccreditation failed, CAR-T services would cease immediately, and would require patients to be referred to centres in England. BMT services would likely be decommissioned locally, with alternative provision commissioned in England. This contingency had been under discussion with the JCC for over two years. The organisation had ruled out seeking derogation, which meant external provision would be the only option.

For an update to come back to the following Quality Committee on 30th June 2026 – ACTION.

	KW expressed concern that no clear contingency plans were in place, despite two years of discussion with the JCC. It was noted that reliance on external commissioning was not a quick or simple solution and suggested the need for escalation to the JCC given the risks sat beyond local control. JC highlighted that there had been ongoing engagement with the JCC. A workforce paper was due to be submitted to them shortly, with a further meeting planned pre-submission. JC sought advice needed on requirements for commissioning alternative services, whilst continuing focus on achieving reaccreditation. **The Committee resolved that:** a) The significant risk and ongoing mitigating actions being progressed across the SWBMT Programme, Specialist Services Clinical Board, the wider Health Board and partners, were noted. 3.4.4 - HIW Short Stay Surgical Unit (SSSU) AS provided the following summary to the Committee: - The paper outlined an unannounced Health Inspectorate Wales (HIW) inspection of the SSSU in January 2026, which identified immediate concerns around patient safety, medicines management, environment, governance, and staff experience. Correspondence with HIW following inspection and staff survey results also raised workforce concerns. - Urgent actions were taken by the Clinical Board to address these, including improving medication controls, securing patient records, and deep cleaning. - Many issues were linked to unscheduled weekend openings of SSSU to meet additional demand without adequate support, now addressed through forward planning and risk-based preparation. - Workforce concerns from staff feedback were reviewed which included rostering and workforce practices, opportunities for staff to access training and education, ad support for staff who had periods of absence or leave. An immediate review was undertaken by the health roster team, which did not identify immediate concerns, though further monitoring continued. - All actions within the HIW improvement plan were either complete or on track, with strengthened audits, infection control, governance processes, and patient accessibility improvements in place. - The People & Culture team had helped to support and had undertaken a culture leadership and education programme across the department. The work was in its diagnostic phase, but there had been staff engagement so that everybody could talk about their experiences. VBA compliance had already increased from 70% to 94%, and mandatory training had improved. - A wider organisational response had been initiated, including UHB-wide audits around medication safety and storage, standardised health promotion materials, proactive accessibility assessments, and development of an HIW inspection readiness tool to ensure consistent quality and compliance across services. CB asked how the proposed HIW inspection readiness tool quality assurance tool aligned or linked to the QMS. AS responded that this formed a core element of the QMS, alongside the Clinical Audit Forward Plan. Both were essential components, as the system relied on all measures collectively. CB suggested extending the quality assurance approaches to the community, public health, and other services without established systems.	

	AS responded the QMS approach was being embedded across all levels, including clinical boards and specialties, though coverage in community services remained variable. Early work was underway to strengthen this. A QMS would not reveal unknown issues but would enable a whole-system view (e.g. linking NICE compliance to outcomes, understanding impact, and targeting improvement). **The Committee resolved that:** a) Assurance was taken from the actions completed to address immediate patient safety risks and the progress made against the HIW improvement plan, noting that all actions are either completed or on track within agreed timescales; b) The ongoing People & Culture review was noted.	
	Items for Oversight / Scrutiny	
QC 2026/06/4.1	**Clinical Audit Highlight Report** 4.1.1 - Additional Learning Needs (ALN) Internal Audit report update Natalie Vanderlinden (NV), the Designated Education Clinical Lead Officer, provided the following summary to the Committee: • The report provided assurance on progress following the internal audit in December 2025 on the implementation and progress made against the ALN reforms. • The ALN reform, introduced in 2021, represented a major change to how children and young people with ALN were identified, assessed and supported, with statutory responsibilities for the UHB, particularly through legally binding Individual Development Plans (IDPs). • The audit gave a reasonable assurance but identified required improvements, including an ALN governance policy development, workforce training, multi-agency working, and statutory compliance monitoring. • Progress had been made across all objectives, with many actions completed and others underway, particularly those dependent on finalising the ALN Governance Policy. • Key improvements included strengthened partnerships, emerging systems for managing referrals and data, and development of national KPIs and dashboards. KW noted concern that some actions had been marked as ‘complete’ despite still being in progress (e.g. policies are still out for consultation) which risked false assurance. KW sought clarity on when the UHB would achieve full legal compliance. NV responded that statutory ALN KPIs (under the ALNET Act) would begin All-Wales reporting from September 2026, with the first dashboard (based on August’s data) providing an initial view of compliance and statutory duties. VB highlighted that actions should demonstrate measurable impact, not just activity, with clear evidence that improvements were meaningful and effective. Emma Cooke (EC), the Executive Director of AHPs, Health Scientists and Community Services Development, acknowledged that ALN implementation was complex, and involved legal duties and partnership working. The audit helped to identify assurance gaps and focus improvement. Whilst progress was strong, emphasis was on ongoing assurance rather than “tick-box” completion. The introduction of All-Wales KPIs would support benchmarking.	

	For progress made against the ALN KPIs and legislation to return to the Committee in early 2027 – ACTION. **The Committee resolved that:** a) Progression to finalisation and implementation of the ALN Governance Policy was supported; b) Strengthened training and workforce oversight arrangements was endorsed; c) Continued development of multi-agency working arrangements was supported; d) Statutory compliance monitoring was strengthened; e) Governance effectiveness and engagement was monitored. 4.1.2 - Clinical Audit Forward Plan 2026/27 AS provided the following summary to the Committee: • The Clinical Audit Forward Plan formed part of the QMS to provide assurance against evidence-based standards and drive improvement. • It outlined a comprehensive but dynamic audit programme, with risks noted around resourcing national (Tier 1) audits due to reliance on clinicians, which could affect data quality. Tier 2 audits focused on quality and safety priorities. • Oversight sat with the Clinical Effectiveness Committee (CEC), with delivery supported by Clinical Boards. • Multiple systems (e.g. AMAT, Q-Pulse, Tendable) were used to manage audits. KW asked what actions would be taken to address the 'alert' findings in the cover report and mitigate the associated risks. AS responded that resourcing of national audits was under review with Clinical Boards and the Executive Medical Director, as current models varied and could impact data quality and delivery. A hybrid approach (combining dedicated audit staff with clinical engagement e.g. SSNAP model) was seen as best practice, with Clinical Boards expected to set timelines to achieve this. **For information to be circulated to Committee members on the actions being taken to address the 'Alert' from the report - ACTION** **The Committee resolved that:** a) The breadth of the Clinical Audit Forward Plan and participation in the national clinical audit and outcome review plan was noted.	
QC 2026/06/4.2	**Clinical Board Quality highlight reports** CP noted the highlight reports were a welcome improvement which replaced the previous Clinical Board reporting and attendance. JR highlighted that a new reporting format which used the Triple-A framework to strengthen assurance by clearly identifying and managing Clinical Board risks, rather than showcase achievements. It highlighted the key risk themes, aimed to improve visibility for Independent Members, and supported deeper scrutiny or follow-up where required. KW explained that it would be helpful to track whether risks were reducing, stable, or escalating to help identify emerging issues and themes across Clinical Boards. **The Committee resolved that:**	

	A) The Clinical Board highlight reports were noted for assurance.	
QC 2026/06/4.3	**Annual Reports** 4.3.1 - Claims Annual Report 2025/26 AH provided the following summary to the Committee: • Claims activity was increasing (in line with Wales) which reflected systemic risks rather than isolated issues, particularly delays in care, decision-making, communication, and estates. • Whilst processes for managing claims were robust, challenges remained in embedding system-wide learning. Current programmes aimed to strengthen consistent, system-led improvements, supported by future changes (e.g. Duty of Candour). **The Committee resolved that:** a) The increase in claims activity and associated system risks was noted; b) The escalation of key risks relating to the below were recognised: o System reliability and pathway delays o Gap between learning and assurance o Estates and environmental risks c) Assurance was sought on the below: o Strengthening of escalation and diagnostic pathways o Evidence of measurable and sustained learning o Reduction in reliance on individual compliance vs system controls d) Escalation of key risks to the organisational risk register where required was supported. 4.3.2 - Patient Experience Annual Report 2025/26 AH summarised the report which provided assurance on a mature patient experience system aligned to the People Experience Framework and the Health and Social Care Quality and Engagement Act, supported by significant volunteer contribution and a wide service offer. It highlighted strong activity and impact with a clear focus on accessibility and improvement. A maturity matrix had informed priorities and objectives for the coming year. **The Committee resolved that:** a) The Patient Experience Annual Report 2025-26 was received for assurance on the effectiveness of systems for capturing, responding to, and learning from patient experience; b) Assurance was received from the evidence of high levels of patient satisfaction and the impact of experience-led improvements; c) The priorities for 2026-27 were noted; d) Continued organisational focus on embedding patient experience as a core driver of quality, safety and service improvement was supported.	
	Policies for Approval	
QC 2026/06/5.1	*No policies for approval.*	
	Items for Noting / Information	
QC 2026/06/6.1	Safeguarding Steering Group (SSG) Highlight Report – 11.03.2026 **The Committee resolved that:**	

	a) The minutes from the SSG meeting on the 11.03.2026 were received for noting.	
	Items Needing Escalation to Board	
QC 2026/06/7.1		
	Any Other Business	
QC 2026/06/8.1	*No other business was raised.*	
	Review of the Meeting	
QC 2026/06/9.1	*Committee members were asked to fill out the Committee Self-Effectiveness survey.*	
	Date & Time of Next Meeting:	
QC 2026/06/10.1	*30th June 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. Kept as "in progress" noting that data will be circulated between April and September. Will move action to "complete" once data circulated.
Theatres Together Programme	QC 2026/06/3.4.1	For an update on progress against the Theatres Together Improvement Plan to return to a future Quality Committee.	Catherine Wood	Catherine Wood	02/06/2026	29/09/2026	ON FORWARD PLAN	Item scheduled for the Quality Committee being held on 29th September 2026.
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	28/07/2026	IN PROGRESS	Update to be provided prior to the Quality Committee being held on 28.07.2026
JACIE Inspection Update	QC 2026/06/3.4.3	For an update to come back to the following Quality Committee.	Jessica Castle	Jessica Castle	02/06/2026	28/07/2026	ON FORWARD PLAN	Item added to the Forward Plan for the 29th July 2026 Quality Committee meeting - item deferred from June to July's meeting following JACIE submission as there was no update for 30.06.2026
Additional Learning Needs (ALN) Internal Audit report update	QC 2026/06/4.1.1	For an update on progress against the ALN KPIs and legislation to be brought back to the Quality Committee in early 2027.	Emma Cooke	Natalie Vanderlinden	02/06/2026	26/01/2027	ON FORWARD PLAN	Added to the Forward Plan for 26th January 2027 Quality Committee meeting.
Clinical Audit Forward Plan 2026/27	QC 2026/06/4.1.1	For information to be circulated to Committee members on the actions being taken to address the 'Alert' from the report.	David Fluck	Alexandra Scott, Aled Roberts	02/06/2026	29/09/2026	ON FORWARD PLAN	Aled Roberts confirmed a paragraph would not be sufficient to capture the diversity, and that a review would be undertaken and brought back through a future Committee.

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

ITEMS FOR ALERT		
Issue / Risk	**Actions Taken**	**Group Responsible**
Infection Prevention and Control: A small increase in *Clostridioides difficile* cases has been identified within one ward area, alongside six *E. coli* cases reported in May. This highlights the need to maintain consistent compliance with infection prevention practices and care bundles.	A MCB action plan has been developed, including the introduction of four targeted care bundles, with a specific focus on catheter care. A targeted improvement plan is in place for the ward area, including focused teaching sessions (May–June), enhanced audit oversight, and clear expectations regarding training attendance. A peer audit approach is also being explored to strengthen ownership and reliability of audit processes. IPC learning panels have been introduced to provide structured oversight of RCAs, support the identification of themes and trends, and strengthen shared learning across the Clinical Board. Infection trends and audit compliance continue to be monitored through established governance processes.	MCB IPC
Datix Processes and Incident Management: Ongoing challenges in the timely review and progression of Datix incidents, with some cases not consistently moving through to management review or closure. This presents a risk to timely oversight, organisational learning, and assurance.	Focused work is underway to strengthen Datix processes across the Clinical Board. The "Every Day is a Datix Day" initiative has improved oversight, with a significant number of previously unreviewed incidents progressed to management review or actioned and closed. Further actions include reinforcing expectations for timely incident review, promoting routine oversight at ward and directorate level, and encouraging staff to utilise available Datix training and support sessions.	MCB QSE

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 improve, with five overdue NRIs scheduled for closure in June 2026 (four of these forming part of a thematic review). A targeted programme is in place to reduce the backlog, including a traffic light tracking system to monitor progress, weekly oversight with the Director of Nursing, and direct follow-up with reviewers to support timely completion. Improvement plans are being actively reviewed to ensure actions are implemented and embedded, with progress monitored through governance processes.	Director of Nursing/MCB QSE Leads.
Concerns- increasing complexity and demand	Further work is required to strengthen the management of concerns, including developing more consistent approaches to theming high-volume enquiries and improving the consistency of responses. Further analysis is being undertaken to better understand the nature, themes, and drivers of concerns, to identify any recurrent issues and opportunities for improvement. Focus is also being placed on strengthening early engagement with patients and families to support resolution at an earlier stage and reduce escalation.	Director of Nursing

Risk Register (AMaT) Oversight	Work is ongoing with directorate teams to review, update and upload risk registers onto AMaT, strengthening consistency, visibility and oversight of risk across the Clinical Board.	Director of Nursing & Ops
Quality Learning and Improvement	A programme of monthly case-based learning is being introduced through MCB QSE to strengthen thematic review and shared learning. Initial focus includes sepsis-related themes, with upcoming sessions on Duty of Candour to support consistency and organisational learning.	MCB QSE
Length of Stay and Quality Impact	Sustained pressure on patient flow and length of stay continues to present a risk to quality, including increased risk of deconditioning, hospital-acquired harm and delayed discharge. Work is ongoing to through exemplar ward work and reduce avoidable delays and close additional capacity.	MCB SMT

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Falls and Pressure Damage- Falls and pressure damage remain key patient safety priorities. There is no current evidence of deterioration, with improving performance observed.	Established Falls and Pressure Damage review panels continue to provide consistent oversight, supporting structured review, shared learning, and improvement. A central quality dashboard has been introduced by the corporate nursing team, enabling monitoring of performance per 1,000 bed days and improving visibility of trends. A reduction in falls has been noted based on per 1,000 bed day data, indicating the positive impact of ongoing interventions and strengthened governance.	MCB QSE -Falls Panel -Pressure Damage Learning Panel
Quality and Safety Governance: Effective governance processes are essential to ensure consistent oversight of quality and safety across the Clinical Board.	Work is underway to strengthen governance processes through the development of a standardised Quality and Safety SOP, supporting clear escalation pathways, defined roles, and improved consistency of information flow. Progress continues to be reviewed through QSE, with a focus on embedding consistent practice and strengthening oversight across directorates.	Clinical Director for Quality and Safety
Cross-Clinical Board Investigations	Two high-profile cases involving multiple Clinical Boards are currently under investigation, led by Specialised services. Whilst not directly managed within MCB, these cases may generate wider organisational learning and will be monitored for relevant themes and actions.	Clinical Director for Quality and Safety

RECENT LEARNING OPPORTUNITY			
Source:	MCB IPC Meeting	**Reference (if applicable):**	NA
What happened / what was the problem?			
Delays have been identified in the completion of HCAI monitoring tools, impacting the robustness of ongoing assurance and oversight			
What was learned and how was this shared?			
Delays were identified in the completion and review of HCAI tools, with a potential impact on the timely escalation and reporting of NRIs where applicable. This issue has been reviewed and discussed between the IPC team and the Deputy Director of Nursing (DDON) and the wider MDT.			
What action has been taken or planned? What was the impact of this?			
IPC HCAI learning panels have been established to facilitate structured review of HCAI tools and to support shared learning.			

The introduction of IPC HCAI learning panels is expected to enhance patient safety and quality of care by strengthening the review and oversight of HCAI tools. This facilitates the timely identification of recurrent themes, supports the consistent dissemination of shared learning, and improves compliance and assurance in relation to surveillance and reporting requirements, including NRIs.

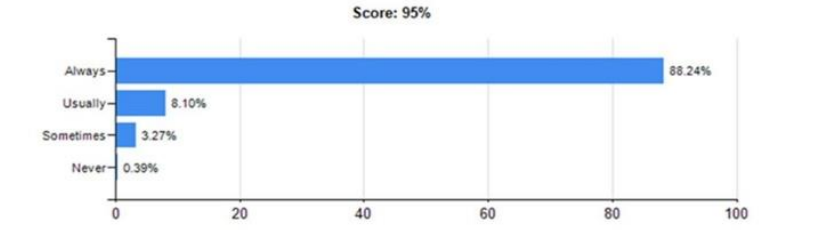
HIGHLIGHTS OF GOOD PRACTICE TO SHARE

IPC HCAI learning panels have been introduced within the Clinical Board to support the structured review of cases and determine whether infections meet the criteria for reporting to NHS Performance and Improvement. The panels provide a multidisciplinary forum to enhance decision-making, strengthen oversight, and maximise shared learning.

Positive results have been received through the **People's Experience Survey** (PES) from patients discharged in April and May 2026. Results can be seen displayed, below, 88% of patient responded that staff were always kind and caring. Further work is being done to monitor and track the trends over time. Further compliments have been received where the high standard of care has been recognised. An example of a compliment on Ward B7, UHW: *'I received the very best of care with patience, kindness and humour. All the staff were fantastic, and I felt very well looked after, treated with dignity and kindness at a time that was frightening for me'.*

Question 3: Were staff kind and caring?

Available Answers	Responses	Score (%)
Always	675	88.24%
Usually	62	8.10%
Sometimes	25	3.27%
Never	3	0.39%
Total	**765**	**100%**



OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

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

NEW / CLOSED / AMENDED RISKS

CLINICAL BOARD QUALITY UPDATE REPORT			
Governance Group:	SCB QSE	**Date of Report:**	26th May 2026
Representative at Clinical Board Governance:	Clare Wade	**Date of Meeting:**	

ITEMS FOR ALERT		
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 any contributory factors, emerging themes, and opportunities for learning. To return to SCB QSE in July 2026 to look at themes which will be shared across the clinical board as required if any learning	Infection Prevention and Control / Clinical Board
Incomplete discharge advice letters (DALs) within EPMA are creating a potential patient safety risk.	Work is underway to improve Clinical Board dashboard visibility, clarify ownership within clinical teams, and strengthen performance oversight in relation to compliance. Monitoring will sit with General Managers and be reviewed through Clinical Board directorate performance meetings.	Clinical Board / Digital / Clinical Teams
Estates and environmental issues are impacting infection prevention and control, including ward bathroom conditions raised through HIW feedback.	The environmental audit process has been revised to include bathroom areas, peer review audits have been introduced, and escalation expectations have been clarified.	Nursing Leadership / Estates / Housekeeping

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Potential discrepancy in sodium readings from point-of-care machines when compared with laboratory biochemistry results.	The Point of Care Group has been asked to confirm calibration and consistency across devices. Interim mitigation is to interpret point-of-care sodium results alongside laboratory values where clinically indicated. This has been shared widely across the Clinical Board for awareness	POC Group
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.	Clinical Board / UHB Governance Team

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Sustained reduction in healthcare-associated infection metrics in Calender year 2025- 2026 , including *Clostridioides difficile*, *Escherichia coli*, and *Klebsiella*, compared with the previous year.	This has been supported through continued focus on hydration, improved documentation, and consistent application of	Infection Prevention and Control / Clinical Teams

	catheter care bundles.	
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
HSDU shutdown and reopening.	The shutdown and subsequent reopening were completed successfully without disruption to theatre activity, supported by effective cross-site collaboration and staff flexibility.	Theatres / HSDU / Sterile Services
Investigation of a hemiarthroplasty infection cluster.	The full MDT review chaired by microbiology in May 2026 concluded that there were no common causative factors. Findings were considered to relate to case complexity and workload, and no recurrence has been identified.	Orthopaedics / Infection Prevention and Control

RECENT LEARNING OPPORTUNITY

Source:	Concern and HIW contact	**Reference (if applicable):**	

What happened / what was the problem?

A cluster of environmental concerns, including ward bathroom condition, was identified externally through HIW feedback, alongside an increase in *Clostridioides difficile* cases and wider infection prevention and control pressures associated with estates challenges.

What was learned and how was this shared?

This highlighted gaps in the visibility provided by existing audit processes and the risk of normalisation within deteriorating environments. It reinforced the need for peer review, a broader audit scope, and proactive escalation. Learning was shared through the Quality and Safety Forum and senior nursing communications.

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

Audit processes were strengthened to include bathrooms and wider environmental checks, with peer review audits introduced and escalation expectations clarified. Early improvements have been noted, including rapid rectification of identified issues and increased organisational focus on estates risks affecting infection prevention and control and patient experience.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

- Significant year-on-year reduction in key infection metrics, including *Clostridioides difficile*, *Escherichia coli*, and *Klebsiella*.
- Strong multidisciplinary engagement in a complex MRSA root cause analysis, recognised as an example of good practice.
- Effective management of the HSDU shutdown, maintaining continuity of theatre activity.
- Proactive identification and investigation of infection clusters, demonstrating effective governance oversight.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

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

ID 82094 ID 91732 ID 82952	Development of a Health Board standard operating procedure for referrals and follow-up, including defined documentation standards, tracking arrangements, escalation timeframes, and role clarity. s.		Transition to digital clinic outcome recording, removing paper clinic outcome forms and improving 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

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:**	26/05/2026
Representative at Clinical Board Governance:	CB, O&G, ACH, CYPFHS	**Date of Meeting:**	

ITEMS FOR ALERT		
Issue / Risk	**Actions Taken**	**Group Responsible**
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. 2. Assessment and management by EWMH Team's including Crisis team and IHTT. Out of hours on call medical team. 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 4. Medical on call rota available out of hours 7 days a week 5. Escalation process for admission and sourcing of appropriate bed in place but it is not functioning effectively	C&W CB / MH CB
Insufficient capacity in ICCNS to deliver statutory care packages (RR 20)	Approval and external advertisement of Band 3 and Band 5 posts. We have recently recruited3 WTe band 3 support workers and intend to seek 4 WTE band 5s via std streamlinging 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	C&W CB, CYPFHS, ECOD
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	C&W CB, PCIC, SB UHB,

Richmond support services (domiciliary support) arm of Richmond Nursing Agency disbanded. 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 and Corporate Governance it was felt this was the only option for the immediate period.	Continued support of use of Beelong Agency for the immediate period. Carys Fox supporting investigation of alternative approved governance agency options. Alternative CIW approved and framework providers to be in place in July CSIW have been informed of the interim arrangement.
National Respiratory Audit Programme (NRAP) Asthma Audit outlier status	University Hospital of Wales has been identified as an outlier within the National Respiratory Audit Programme (NRAP), in line with the NRAP outlier policy This service has been identified as non-participating hospital/service in the children and young people's asthma audit, for the 1 April 2024 and 31 March 2025 cohort period.	Support has been arranged to maintain compliance going forward

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group Responsible**
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.	O&G
Ongoing HV JD review	Move via UNITE to move HV's in C&V to a collective Grievance stage	WG
Restarting children's rights forum	Dates being arranged and stakeholders identified	C&W CB
Plan for ND delivery plan has gone to UHB Finance Group for ratification	Awaiting outcome from UHB Finance group	UHB Finance Group
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.	C&W CB ECOD, Finance

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

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.	HIW
Recording and Monitoring of Directorate & Clinical Board Risks	All risks have been transitioned to the AMAT system in line with UHB. Regular monthly monitoring and review undertaken across Directorates with monthly reviews being undertaken of all >20 risk rating by the Clinical Board. 3monthly reviews are also being scheduled by Clinical Board to review all risks on an ongoing basis.	AMaT support team
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.	

RECENT LEARNING OPPORTUNITY			
Source:	Paediatric VTE Protocol	**Reference (if applicable):**	

What happened / what was the problem?

Cardiff & Vale UHB was using an adult VTE protocol for paediatric patients, which was not appropriate as there was no paediatric-specific protocol in place.

What was learned and how was this shared?

An audit showed VTEs are extremely rare in children under 13, with most cases occurring in acutely unwell patients (especially those with central lines, sepsis, or cancer) aged 13–17. National UK guidelines and literature were reviewed, and a multidisciplinary team (consultant haematologists, anaesthetists, specialist nurses) collaborated to develop a new protocol.

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

A new protocol was created for inpatients aged 13–17, focusing on risk assessment, regular reassessment, and clear dosing for enoxaparin. The protocol excludes outpatients and children under 13 unless there are exceptional clinical circumstances. Changes included specifying enoxaparin (not generic LMWH), simplified dosing, and an "other risk" box for clinical discretion.

The protocol will now be implemented for use. It is expected to improve clarity, ensure appropriate treatment, and reduce unnecessary risk assessments for younger children. Support is in place for rollout and use.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Concerns management improvement

Investigating Officers are being followed up actively through concerns tracker meetings. Previously, a high number of cases had gone beyond 75 and 100 days, with many others not answered within the 30-working-day timeframe.

A proactive approach is being taken to support timely responses, including spotting and resolving barriers before deadlines are reached. This has helped Investigating Officers move responses forward more quickly and has improved engagement and overall outcomes.

The drop in overdue concerns has been clear. At the time of writing this report, there are only four outstanding Obstetrics and Maternity concerns, all within timescales. This is a significant improvement on previous years, when backlogs were a regular issue.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS				
Case No	**Action**	**Due Date**	**Reason for Non Delivery**	**Risk (RAG)**
	1 overdue maternity HIW action			
	X4 Overdue NRI's:			
IN90636 (RA)	PSLR being reviewed	Oct 2025	Sent for final review with deadline set for 5/6/2026. Anticipated to submit for approval and closure w/c 8/6/2026	
IN29271 (AJH)	PSLR initiated following grading of Perinatal Mortality Review	Jan 2026	Originally reported as MBBRACE. Care concerns noted following PMR, PSLR initiated. Anticipated closure June 2026. Closure meeting set for 04/06/2026	
IN102543 (PT)	Final Draft to be shared with Patient Safety Team by 26.05.2026	April 2026	PSLR progressing. IO had recent period of sickness. Anticipated closure June 2026	
IN101360 (RR)	PSLR being reviewed	May 2026	Further review required following additional concerns raised at patient debrief session that require consideration as part of the review.	

NEW / CLOSED / AMENDED RISKS

None to note

CLINICAL BOARD QUALITY UPDATE REPORT			
Governance Group:	Quality Committee	**Date of Meeting:**	30.06.2026
Representative at Clinical Board Governance:	PCIC Clinical Board Quality, Safety & Experience Group	**Date of Meeting:**	

ITEMS FOR ALERT		
Issue / Risk	Actions Taken	Group Responsible
HMP National Reportable Incidents and near miss incidents with theme predominantly around Mental Health Provision	Clinical board to Clinical Board escalation and collaboration to review processes. Rapid Review process and NRI investigations Collaboration with HMP	PCIC & Mental Health Clinical Board
District Nursing Escalation - level 4 due to unavailability of staff (Vacancies 18.75 WTE RN and sickness)	Daily prioritisation of calls, transfer of staff across teams/boundaries to mitigate risks. SBAR to EDON and Director of Strategic Nursing	PCIC CB & UHB/Corporate Nursing for Nurse Recruitment Strategy
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

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. 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	Workforce review in HMP and review of opportunities for workforce reshaping Cross Clinical Board working and collaboration around Mental Health Provision Establishment/Funding review	PCIC Clinical Board

recommendations from PPO and HMP Health Needs Assessment will require workforce additionality.		
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

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Rapid Assessments tools completed for		
HIW Inspections in Primary Care with our commissioned partners	Primary Care team work with practices on immediate assurance actions, are followed up with the practice, support offered where necessary and assurance of completion is provided.	Primary Care Quality & Safety
Risk Register Transfer to AMaT completed and CB do undertake a deep dive with view to derisking clinical risks	Monthly review & deep dive	PCIC Clinical Board
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
Rapid review process for Serious Incidents	Present to weekly Corporate	PCIC CB & UHB Corporate teams

RECENT LEARNING OPPORTUNITY			
Source:	Concern	**Reference (if applicable):**	
Patient end of life experience impacted by regional boundary and care responsibilities issues and differing documentation.			
What action has been taken or planned? What was the impact of this?			

Work with Aneurin Bevan and Cwm Taf to review boundary arrangements for patients residing on the borders of Health Boards.

CAV Implementation plan for adopting the All-Wales Syringe Driver chart being progressed alongside a training plan.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Updated Terms of Reference for CHC Quality Assurance after benchmarking with other HB's

Hepatitis A outbreak, vaccination programme and management alongside PHW

Weekly pressure damage scrutiny panels in place

Proactive monitoring of Section 5 and Safeguarding referrals

Concerns tracking and Standard Operating Procedure to improve response times against KPI's and to comply with "Listening to People" regulations

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

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

NEW / CLOSED / AMENDED RISKS

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**
Lack of robust electronic requesting system for receipt of an escalation of radiology results with significant findings- how referrers review and action results, already on risk register but raised recently as part of NRI process	Electronic requesting system requires UHB wide approach- being picked up with PST	
The UHB Green Group shared the results of the UHB Heatwave Survey and the findings indicated that Therapies. Laboratory Medicine and Pharmacy were most affected by the heat with staff, patients, equipment and reagents all affected.	Mitigations putting in place such as sourcing fans, keeping patients hydrated, moving rehab sessions to the mornings when the temperature was cooler. Moving stock to different areas of the labs.	UHB Green Group

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group Responsible**
The new RISP system in Radiology is now live. This has been a major, complex and extremely challenging programme to replace the existing Radiology Information Systems (RIS) and Picture Archiving and Communication Systems (PACS), with a single, modern, integrated radiology solution across NHS Wales.	Implemented on 1st June 2026	RISP Implementation Group
MHRA inspection of blood transfusion planned for 22nd June	Preparatory actions taken	CD&T regulatory compliance and QSE sub-committee

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Moderation exercise of directorate risk registers discussed. Top 5 risks by directorates discussed • Capacity and demand in radiology linked to delayed reporting. • Lack of robust electronic requesting system for receipt of an escalation of radiology results with significant findings- how referrers review and action results • Ageing equipment raised in clinical engineering and medical physics. Equipment issues discussed more widely to include wok in therapies relating to loaned equipment and complying with LOLER regulations- working with health and safety colleagues to try and resolve. Radiology equipment failures was also discussed. • Roll out of LIMS implementation delays impacting on blood sciences go live dates discussed- • Laboratory space constraints discussed new born screening and stem cell- business cases	Individual meetings to be arranged • Directorate working on plans to address gap, reporting radiographers and outsourcing has improved plain film backlog • Electronic requesting system requires UHB wide approach- being picked up with PST • Quarterly report of radiology equipment issues to come to QSE sub committee • Delays raised in LIMS programme board	Directorates and QSE sub committee

	• Business cases in development and stem cell linked to JACIE task and finish group	
Backlog in plain film reporting was a factor in NRI process led by MCB.	Directorate have improved backlog position greatly by combination of outsourcing and training more reporting radiographers to support more timely reporting	CD&T QSE sub committee
2 IR(ME)R incidents under investigation and 2 waiting dose assessment	Investigation commenced due 6/7/26	RMPCE directorate

RECENT LEARNING OPPORTUNITY			
Source:	Therapies Directorate Performance Review - Quality Showcase	**Reference (if applicable):**	

What happened / what was the problem?

The Podiatry MSK service has undergone a significant transformation, placing patients at the centre, improving clinical consistency, using resources more intelligently, and embedding sustainability—creating a model for future value-driven healthcare delivery.

What was learned and how was this shared?

The service redesign aligns with value-based healthcare, prudent healthcare principles and the rehabilitation model. All service changes align with the four pillars—personal, technical, allocative, and societal value.

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

- **Personal Value:**
  - Introduction of PROMs and PREMs via the *Promptly* platform to capture real-time patient outcomes and experience.
  - Strengthened self-management approaches and development of standardised care pathways to ensure consistent, high-quality care.
- **Technical Value:**
  - Ongoing standardisation of treatment protocols to reduce unwarranted variation.
  - Expansion of advanced in-house interventions, including point-of-care ultrasound and corticosteroid injections, reducing reliance on Radiology and secondary care.
  - Active involvement in research and national pathway development, including contributions to MSK guidelines and GP Health pathways.
- **Allocative Value:**
  - Orthotic and materials stock reduced by 48% through evidence-based audits.
  - Continued focus on reducing waste and ensuring only value-adding interventions are used.
  - Strengthened Quality Management System (QMS) and MDR processes to support safety, traceability, and regulatory compliance.
  - In-house advanced treatments projected to save the Health Board £73k annually.

- **Societal Value:**
  - Increased use of virtual follow-ups, reducing unnecessary face-to-face appointments and lowering carbon impact.
  - Work with suppliers to repurpose unused orthotic components, supporting circular economy principles.
  - Exploration of fee-paying adjunctive treatments to support patient motivation and generate income.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

SLT colleague Dr Laura Hrastelj research published in Health Care Research Wales [Supporting children who communicate differently: how one child inspired Dr Hrastelj's research career | Health Care Research Wales]

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

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

NEW / CLOSED / AMENDED RISKS

Estates issues discussed including ongoing and new leaks in SDEC corridor, medical physics, pharmacy, health records and UHW physio, estates colleagues aware and working on mitigation.

High temperatures within ultrasound department in UHW reported, impacted on staff wellbeing and patient experience, air conditioning units end of life, PIE submitted

Hydro pool in UHW remains closed, a number of concerns raised as unable to re-provide, land therapy offered as alternative. Timeframe for completion of corrective works tbc

CLINICAL BOARD QUALITY UPDATE REPORT

Governance Group:	Specialist Services QSE Committee	**Date of Meeting:**	17/06/26
Representative at Clinical Board Governance:	Cath Twamley (DON)	**Date of Meeting:**	30/06/2026

ITEMS FOR ALERT

Issue / Risk	Actions Taken	Group Responsible
Notification of a further incident of implantation of an expired pacing device 16/06/26	Rapid Review in progress and will be presented at UHB Quality Meting 24/06/26. (NB This was retrospectively reported and occurred prior to recent actions initiated and a process review following a 'near miss' of same nature).	Physiology team Cardiac Services DMT Specialist services CB

ITEMS TO ADVISE

Issue / Risk	Actions Taken	Group Responsible
Datix ID 115833 & 115849 Critical Care patient with T2DM attended theatre for surgical tracheostomy on CEPOD list and found to be hypoglycaemic with a BM of 1.9 mmol/L. Managed appropriately and no harm. Incident reported from openness and transparency out of clinical curiosity and given recent theme of learning from incidents in relation to hypoglycaemia recognition and management.	Rapid Review presented at Quality Meeting 10/06/26. For discussion at CC QSE 18/6/26. Blood glucose monitoring tool & medication guidance for NBM type 2 diabetic patients to be devised.	Actions to be lead by CC senior nursing team.
JCC advised 03/06/26 that they will be recommending the **Electronic Assistive Technology Service (EATs) in ALAS** be placed into special measures whilst work to reduce the RTT, which was recently alerted as a risk, is progressed. No further update at time of write report.	• Trialling joint training clinics for lower acuity patients • Recruitment of 1.0 WTE Speech and Language Therapist (now in post) • Allocation of 0.4 WTE resource to undertake a service review • Recruitment of 1.0 WTE Band 5 to support waiting list reduction • Validation of waiting list and service spec. • Urgent demand/ capacity review	Specialist Services Clinical Board ALAS & EATs teams

ITEMS FOR ASSURANCE

Issue / Risk	Actions Taken	Group Responsible

IP&C profile on W8/ MRSA outbreak	Review of audits and robust hand hygiene/ BBE actions taken to include sending home non-compliant members of staff and informal discussions	Senior nursing team
Theme of incidents with varying harm to include catastrophic and a PFD relating to heparin infusions	Short Life Working Party for standardisation of heparin infusions in response to a theme of incidents continues to meet regularly and progress actions	SLWP quorum as per agreed TORs, reporting into MSE

RECENT LEARNING OPPORTUNITY

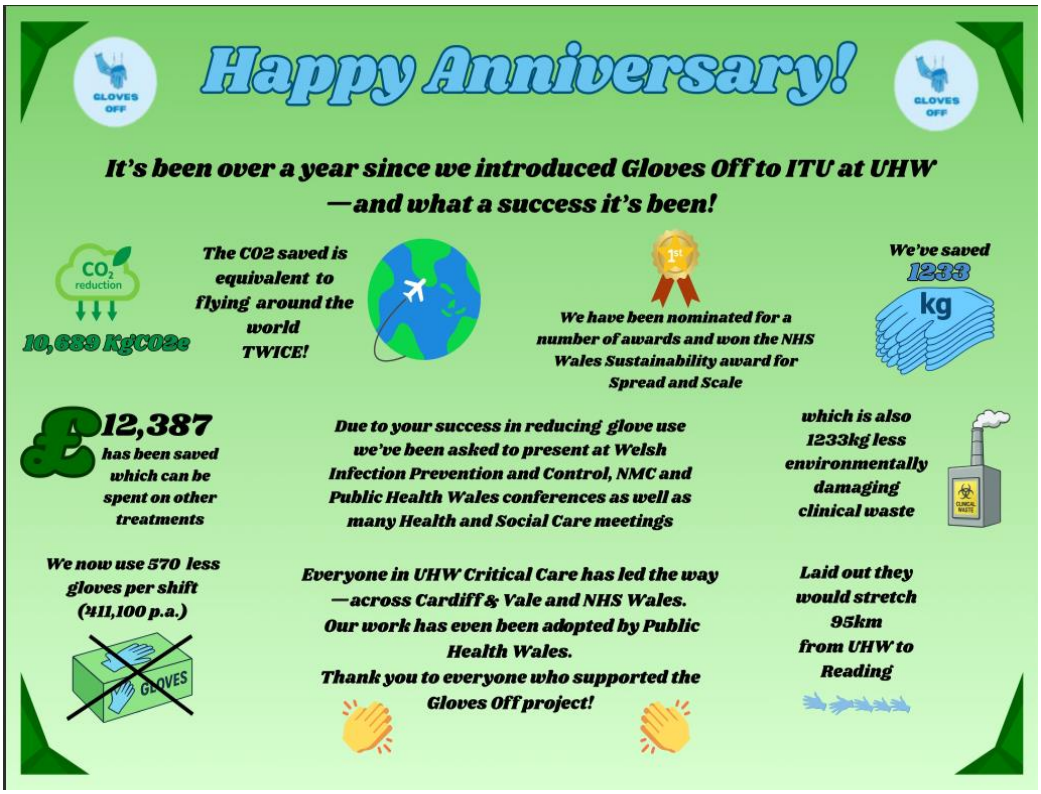
Source:	***N/A for this reporting period***	**Reference (if applicable):**	

What happened / what was the problem?

What was learned and how was this shared?

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

HIGHLIGHTS OF GOOD PRACTICE TO SHARE



OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS				
Case No	**Action**	**Due Date**	**Reason for Non Delivery**	**Risk (RAG)**
101295	Sign off of 'Transplant Service Escalation Plan for Service Gaps'	asap	Drafted and in use operationally, pending consensus of all stakeholders re. detail	Green (on basis document for referral to and accountability)

NEW / CLOSED / AMENDED RISKS

Nil to note for this reporting period

CLINICAL BOARD QUALITY UPDATE REPORT			
Governance Group:	Quality Committee	**Date of Meeting:**	30.06.2026
Representative at Clinical Board Governance:	Mental Health Clinical Board	**Date of Meeting:**	

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. • 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. • 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. • 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. • OOA reduction and patient flow actions are being monitored through directorate and MHCB governance arrangements, with focused oversight of	• 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. • Governance and

	discharge planning, length of stay, escalation and system-wide barriers to flow.	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 Interim Lead Nurse, Adult Mental Health 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 MHCB Performance and Quality Governance arrangements Clinical Board oversight.
Workforce pressures continue to affect resilience across mental health services, including vacancies, sickness absence, temporary staffing reliance and roster fill	The workforce position is being monitored through directorate performance	Mental Health Clinical Board Directorate Management

challenges. This may impact continuity of care, staff wellbeing, quality and financial sustainability if sustained.	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.	Teams 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. A working group is being established to explore a rolling Safety and Stabilisation programme spanning primary and secondary care.	Interim Director of Nursing Interim Director of Psychology and Psychological Therapies Adult Mental Health Directorate 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 consistency and closure of learning actions.	MHSOP Directorate Management Team Interim Director of Nursing Safety Pillar Workstream MHCB Quality and Safety governance arrangements

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 Interim Lead Nurse, Adult Mental Health Adult Mental Health Directorate Management Team 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 Adult Mental Health Directorate Management Team 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 Interim Director of Nursing Interim Director of Operations 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)**

NEW / CLOSED / AMENDED RISKS

Report Title: *(needs to match agenda)*	Annual Report for Complaints, Redress and Inquests		Agenda Item No:		3.2
Meeting:	Quality Committee	Public	☒	Meeting Date:	30 June 2026
		Private			
Lead Executive Title:	Executive Director of Nursing				
Report Author/s Title:	Assistant Director of Patient Experience Head of Concerns and Redress				

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 can be assured that Cardiff and Vale UHB has maintained effective arrangements for managing concerns, complaints, redress and inquests during 2025/26 in line with the Putting Things Right (PTR) Regulations, while continuing transition to the Listening to People (LTP) framework. These arrangements provide assurance that governance, oversight and operational systems are in place to support statutory compliance, risk visibility, organisational learning and service improvement.
Assurance is provided through:

- Strong governance, performance management and oversight arrangements, including proactive case management, Clinical Board engagement and timely acknowledgement and response to concerns in line with statutory requirements.
- Clear organisational visibility of complaints, redress and inquests, with themes, trends, risks and emerging issues reviewed alongside quality and safety intelligence to support escalation and response.
- Systematic organisational learning, with clear recurring themes identified across Clinical Boards, learning shared through governance routes, and actions taken to support service improvement, patient safety and patient experience.
- Effective management of redress and inquests, providing oversight of patient harm, legal risk, learning and case progression through formal panels, structured processes and active engagement between corporate teams and Clinical Boards.
- Strengthening of systems and infrastructure through implementation and continued development of the Complaints Management System (CMS), improving oversight, data quality, reporting capability and compliance with emerging regulatory requirements.
- A clear forward plan under Listening to People, with strengthened corporate oversight, improved use of themes and trends, and systems and processes that support a more consistent, person-centred approach to engagement and resolution.

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

The Committee is asked to:

1. Note the content of the Putting Things Right Annual Report 2025/26.
2. Take assurance that governance, oversight and operational arrangements are in place to manage concerns, complaints, redress and inquests in line with statutory requirements and support transition to the Listening to People framework.
3. Note 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.
4. Support the continued development of the Complaints Management System (CMS) and associated governance processes to strengthen oversight, reporting, compliance and organisational learning.
5. Note the clear forward plan for implementation of Listening to People, supporting a more consistent and person-centred approach to engagement, resolution and learning.

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 report https://nhswales365-my.sharepoint.com/personal/angela_hughes5_wales_nhs_uk/_layouts/15/Doc.aspx?sourcedoc={99E4C2D8-B527-4790-8ABE-6C05C7091A48}&file=Putting things right Annual Report 2026 JC v2.docx&action=default&mobileredirect=true provides assurance on the Health Board's arrangements for managing concerns, complaints, redress and inquests during 2025/26 in line with the **Putting Things Right (PTR) Regulations**.

These functions form a key component of the organisation's wider quality, safety and governance framework, providing insight into patient experience, service reliability and clinical risk.

Activity and Performance

- A total of **3,245 concerns** were received during 2025/26, with changes in categorisation reflecting improved recording of enquiries and early resolution activity.
- Complaints activity demonstrates an **overall upward trend**, particularly in the latter part of the year, linked to pressures relating to access, waiting times and communication.
- Performance against key standards for acknowledgement and response remained strong, supported by proactive management of cases and engagement with Clinical Boards.

Learning and Improvement
Analysis of concerns, complaints, redress and inquests identified consistent organisational themes:

- **Communication and patient experience**
- **Clinical decision-making and safety**
- **Documentation and record keeping**

- **Discharge planning and care coordination**
- **Compassionate, person-centred care**
- **System and process reliability**

Learning has been used to support local practice improvement, pathway redesign and strengthened governance oversight.

Redress and Inquests

- Redress continues to provide insight into **patient harm, system reliability and clinical risk**, complementing complaints data.
- Inquests remain an important source of organisational assurance and learning, with **212 inquests recorded during the reporting period**.
- Learning from inquests and Prevention of Future Deaths reports has informed improvements in communication, safety processes and escalation pathways.
  Transition to Listening to People

From April 2026, the organisation has transitioned to the **Listening to People (LTP) framework**, introducing:

- Greater emphasis on **early engagement and resolution**
- Stronger **corporate oversight and assurance**
- Improved use of **themes and trends to drive system learning System Development**

The implementation of a new **Complaints Management System (CMS)** provides:

- A single-entry point for complaints
- Improved triage, tracking and reporting
- Enhanced oversight through real-time dashboards

This supports compliance with LTP requirements and strengthens organisational learning capability.

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

- **Annual Report for Complaints, Redress and Inquests**

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
Rising complaint volumes and complexity indicate increasing operational and reputational risk; mitigation actions are described within the report
Safety: Yes
Yes – Themes relating to clinical decision-making, discharge and communication highlight direct patient safety implications; actions are in place through governance and learning systems
Financial: Yes
Effective redress management supports cost avoidance when compared to litigation processes.
Workforce: No
Legal: Please select
The report reflects statutory compliance with PTR and transition to LTP regulations
Reputational: Yes
Complaints and inquests have potential reputational impact; proactive learning and transparent reporting mitigate this risk.

Socio Economic: Yes - *https://www.gov.wales/socio-economic-duty-guidance*
Applicable – LTP framework strengthens equitable access and supports improved outcomes for disadvantaged groups
Equality & Health: Yes
Applicable – Actions include improved communication, reasonable adjustments and person-centred care approaches.
Decarbonisation: No
Welsh Language: Yes
Applicable – LTP expectations include accessible communication and reasonable adjustments, supporting Welsh language needs.

Report Title: *(needs to match agenda)*	Quality & Operational Risks (Scoring 20 – 25)		Agenda Item No:		3.3
Meeting:	Quality Committee	Public	☒	Meeting Date:	30 June 2026
		Private			
Lead Executive Title:	Director of Corporate Governance				
Report Author/s Title:	Corporate Archivist & Records Management 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).*

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)*

A consistent, organisation-wide approach to committee oversight of high-scoring risks is not yet fully established. Current reporting arrangements have not provided Committees with full visibility of risks within their remit.

There are currently 193 high scoring risks of 20 – 25 on the Risk Register, all of which are reported to the Board through one singular report. Through the digital implementation of AMaT, all risks have been assigned a Primary Risk Category by the Risk Owner and their team. These categories have now enabled the 193 risks to be split across our five Committees, with 93 risks identified as Quality and Operational and submitted to the Quality Committee in the attached appendices.

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**	☒

Recommendations

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

The Committee is asked to:

1. Note the approach being implemented to align high-scoring (20+) organisational risks to Committee structures, improving visibility and governance oversight across all remits.

2. Support the development of a consistent, organisation-wide approach to risk reporting and discussion within Committees, including integration into forward plans and routine agenda items.

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

Work is underway to strengthen the alignment between organisational risk register and Committee oversight to support improved governance, visibility and assurance.

The proposed model aligns AMaT risk categories to Committee structures, enabling clearer oversight of key risks within each Committee's remit. These are broadly structured as:

Quality – quality and operational risks
P&C – people and reputational risks
F&P – finance, commercial and sustainability risks
D&I – digital, cyber and infrastructure risks
Audit – legal and regulatory risks

Initial implementation will focus on risks with a score of 20+, which will be extracted from AMaT and presented to the relevant Committees in a consistent format.

This approach provides coverage of the majority of high-scoring risks and introduces a structured mechanism for ensuring that Committees have visibility of risks aligned to their remit.

The first phase of implementation will involve presenting these risks to Committees supported by Corporate Governance engagement with Committee Chairs in advance.

At present, Committee approaches to risk discussion are not standardised and will require further development. A programme of engagement and forward planning is being progressed to establish a consistent approach to risk discussion and integration into Committee agendas over time.

This includes updating Committee forward plans, briefing Chairs, and introducing risk as a recurring agenda item, with the intention to develop the approach iteratively based on Committee feedback and use.

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

- **Risk Register (located in the supporting documents folder on MS Teams and the Cardiff and Vale UHB website)**

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 management and maintenance of the Health Board's Risk Register contributes to the Health Board's Risk Management processed and procedures.
Safety: No

Financial: No
Workforce: No
Legal: No
Reputational: Yes
Socio Economic: No
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Shaping Our Future Wellbeing

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

Board Assurance Framework

Updated 28 May 26

Introduction

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

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

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

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

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

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

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

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

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

Shaping Our Future Wellbeing

Strategic Framework

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

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

Shaping Our Future Wellbeing

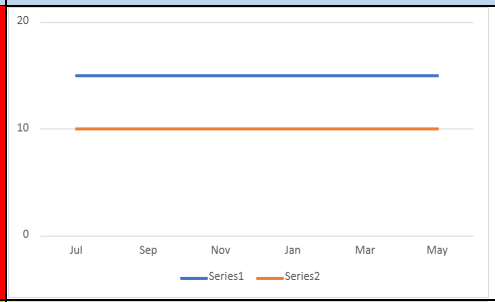
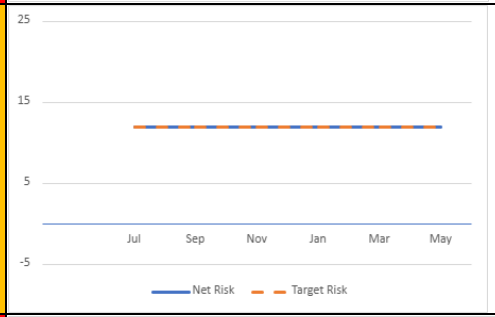
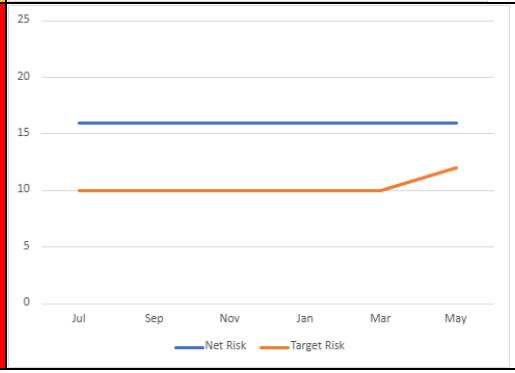
Strategic Objectives

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

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

Strategic Risks – Quality

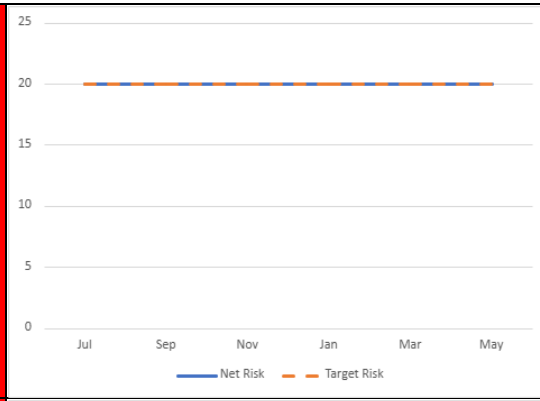
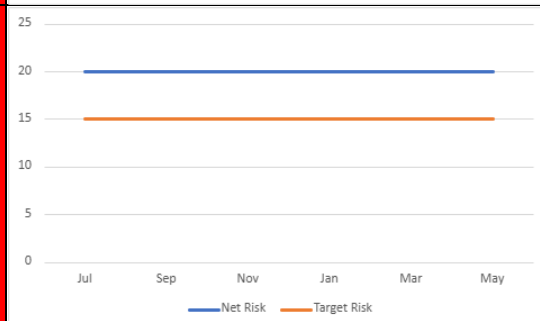
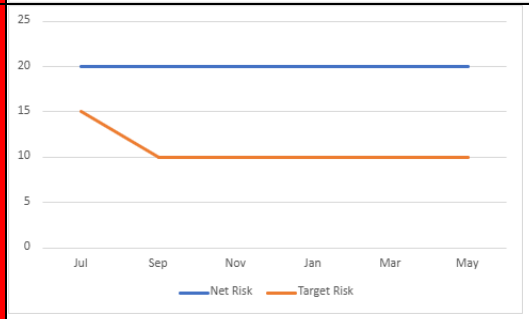
What will prevent Cardiff and Vale University Health Board from delivering its strategy?
If any of the below risk themes cannot be controlled, then the strategic objectives are unlikely to be met.

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

Shaping Our Future Wellbeing

Strategic Risks – Quality

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

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

Strategic Risks – Quality

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

Strategic Risks – Quality

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

Risk

The delivery of poor quality care that has a negative impact on the outcomes and experience of the population we serve

Cause	Impact
Workforce Vulnerabilities in our Workforce including availability, retention, culture and leadership can impact on our ability to deliver safe effective timely and patient centred care **Digital Enablers** The absence of a joined up digital patient record and patient management system has resulted in omissions in care and disruption to patient pathways Ability to deliver effective care is impacted by outdated systems related to digital technology, clinical coding The challenge in accessing real time data to track care against a robust evidence base means that the organisation is dependent on retrospective data to inform its response to quality risk. The lack of data relating to population health and protected characteristics means that we are unable to effectively measure variation in outcomes. **Capacity and demand** Ability to deliver timely care is significantly impacted by the backlog of referrals following the covid-19 pandemic and the mismatch between demand and recurrent capacity within many clinical services. Pressure within the urgent and emergency care pathway is driven by extended length of stay. Opportunities to maximise out of hospital services have not been fully realised. **Environment** The ageing environment is leading to challenges including to disruption to services and Infection prevention and control risks and poor patient experience **Whole Systems approach** Gaps in our clinical governance structure means that risk is not clearly articulated and Escalated and that mitigation is often localised rather than delivered at an organisational level. **Improvement and learning capability** Learning from events is often undertaken at departmental level with infrequent evidence of embedding organisational learning	**Safe** The UHB continues to see a number of same cause patient safety incidents, complaints, redress cases and claims where the harm to patients is potentially avoidable. These include health care associated infections, failure to ensure continuity in clinical pathways, failure to recognise the deteriorating patient, failure to escalate, issues with communication and Never Events. The health, safety and welfare of our staff is not universally maintained. **Timely** Long waiting times for planned care and diagnostics means care is delivered at inappropriate timescales with a potential consequence of progression of disease, worsening wellbeing and associated psychosocial impact on patients and families. Care is ultimately costlier to provide. **Effective** Benchmarked data associated with national clinical audits demonstrates that we don't universally benchmark in the top 30% of organisations nationally for performance and outcomes. The pressure on estates, workforce capacity and wellbeing will impact on our ability to provide care in line with evidence base. **Efficient** The Health Board is not meeting some of its productivity and efficiency ambitions, including in relation to outpatients and length of stay. Care may be being delivered which does not provide value to the patient, wider population and health economy. Care can be duplicative and wasteful. Care is often delivered with a disproportionate focus on intervention vs prevention. Constraints around workforce availability results in a reliance on non UHB staff to provide core. **Person Centred** The Health Board is striving to deliver care that meets the patients right to empathy, compassion, privacy, dignity and respect. In some areas patient experience is below our ambition, for example in the Emergency Department which is below the 85% target in all but one measure. The Health Board is seeking to ensure patients and families views are sought and play a role in improving services.

Strategic Risks – Quality

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

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

Strategic Risks – Quality

Efficient – operational programmes in planned care and urgent and emergency care focused on delivering best practice. Benchmarking and use of GIRFT central to programme. Productivity and Efficiency ambitions in place and monitored. **Person Centred –** Value Based Healthcare programme supporting projects and programmes focused on delivering value to patients. The UHB is rolling out a new PROM platform "Promptly" throughout the organisation to provide reliable opportunities to collect this information. **Equitable –** We monitor performance against the actions outlined in the Equity, Experience and Patient Safety Framework and Action Plan. This goes to Quality Committee every six months.	
Gaps in Controls	**Gaps in Assurances**
A recent advisory audit of Clinical Governance demonstrated gaps in reporting and escalation The availability of data to support benchmarking and monitoring of performance is limited by poor coding compliance Participation in a number of National Clinical Audits is sub optimal with poor case ascertainment and data quality The availability of data relating to protected characteristics means that measures of variation in outcomes by population is limited. The Development of the Quality management system is underway but this is a two year programme to embed this work	The control gaps identified mean that assurance at Committee and Board level is undermined and so the Committee work is being reviewed and redeveloped.

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

Strategic Risks – Quality

Actions			
What	**Lead**	**By**	**Update**
Deliver stroke improvement plan to address quality concerns in acute stroke pathway	PB	30/06/26	• Business case approved for stroke model, funding to be released from Q4 2024/25 • Delays in recruitment for agreed stroke post • Recruitment is now underway to the additional posts, but it will be some time before all posts are in place. There is continued focus on stroke performance and a real increase in regional working to deliver sustainable models moving forwards. • Stroke performance remains stable – new SSNAP measures to be reported to Board in August. • Go-live of phase of regional thrombectomy service in July • Performance is consistent despite operational pressures. Increases in thrombolysis rates, work remains on % in time. Detailed review of thrombectomy undertaken • Stroke summit to review progress planned for 15th January • Stroke summit highlighted improvements in performance for some parts of pathway alongside increased challenges – particularly rehab length of stay. Work ongoing
Develop and deliver improvement plan for cancer and long waiting patients, including a plan to reduce diagnostic waiting times.	PB	31/03/27	• Delivery against revised trajectories is monitored internally and by WG • Challenging position in select specialities including ophthalmology • End of year positions in Cancer and 104 weeks for 24/25 good in comparison to recent years but still too long and not in line with WG expectations. Revised plans in place to deliver reduction during 2025/26 • Cancer performance remains best in Wales – further work to do to reach 75% • Long waits significantly reduced, meeting agreed trajectories for each quarter. • Q2 performance slightly ahead of trajectory for 104 week waits. • On-track of 450 patients waiting longer than 104 weeks by end of March. • Diagnostic challenges mean improvements will be delivered but not to the level previously expected • End of year position significantly improved for 156 weeks, 104 weeks and 8-week waits • Recurrent demand and capacity mismatches will lead to worsening of position in 26/27 without further investment • Delivering productivity and efficiency opportunities key to mitigating position
Develop and deliver long term proposal for ITU capacity – Strategic Outline Case in production	PB	31/09/26	• The design development continues. However, discussions are ongoing with WG in relation to a combined ITU/Haematology and Hybrid theatres schemes.

Strategic Risks – Quality

			• Interim plan for releasing capacity on 3rd floor in progress through discretionary capital programme – Work to C1 to accommodate Cardiology from C3 has commenced and is due to complete October 2025, releasing capacity ahead of the ITU work • C1 work will completed in December. Planning in place to install updated UPS • C1 work completed. UPS completed. • Detailed request for funding for C3 refurbishment, and indicating plans for subsequent A3, B3 upgrades, will be sent to WG in Q4 • Completion of proposal has been delayed due to capacity pressures, aiming for submission in Q2 26/27
Deliver the Theatres Together Programme which includes important quality elements such as the WHO checklist and productivity improvements	PB	31/03/2026	• Theatres Together Programme is underway, and updates provided through Board. Initial focus on 6 immediate actions and cultural priorities • Work on further tranches now underway • Progress made across programme with improvements in staff feedback. • A number of capital and estates improvements have been delivered with wider programme in development • Theatre efficiency and utilisation improvements form significant part of future work
Review, design and improve mental health services which are noted to carry risks to quality	PB/DF	31/03/2026	• External consultancy appointed to support with review of mental health services – work ongoing • Plans for neurodevelopment services undergoing significant scrutiny • 3-year ND waits for children and young people likely to be >450 by March 2026 – working with WG and NHS P&I. • 3-year ND waits reducing for end of life but will increase in 26/27 • Implementation phase of transformation work to begin in 26/27
Length of stay and continuity of care	PB	31/03/2027	• Length of stay programme in place – aiming to deliver, as a minimum, mean peer performance in medicine non-elective by the end of March 2026/27. • Performance and productivity board in place to monitor and drive change
Development of a Quality Outcomes Framework- To support a data informed approach to quality	JR/ RS	31.06.25	• Meetings underway with corporate teams to agree quality indicators • Work to extrapolate data relating to patient safety incidents commenced • Plan to develop a first draft by Q1 with digital support by June 2025 • Publication of a UHB mortality dashboard • Publication and analysis of clinical board and directorate mortality dashboards
Development of the Quality prospectus to populate the quality academy – Up skill staff across the clinical boards in patient safety review technique, improvement planning and clinical governance	JR	31.03.26	• PSLR training developed • Improvement plan training in development • Human factor prospectus planning • Development of a quality academy • Accredited audit training in place

Strategic Risks – Quality

Monitoring of the Equity, Equality, Experience and Patient Safety Action Plan and progress against actions by Clinical Boards	CB	Every six months	• Paper for Quality Committee on progress against the action plan. • Early discussions with Public health around equity measures as part of the quality outcome framework
Review and redevelop the Quality Committee to incorporate Mental Health and accommodate audit points from Audit Wales and Internal Audit	MP/JR/DF	1.06.26	• New format to be used in June meetings

Strategic Risks – Health Equity

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

Risk

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

Cause	Impact

Risk: a lack of investment in prevention
 	
• Our organisation aims to shift spending from reactive hospital care towards prevention and proactive care in community settings. However, secondary care continues to receive an increasing share of NHS funding, leaving prevention under-resourced. Addressing this imbalance is essential for our long-term sustainability.
• There is currently a lack of capacity to deliver evidence-based interventions at scale to tackle smoking, obesity, vaccination, alcohol, substance use etc. that drive the huge disparities in health outcomes we see across Cardiff and the Vale of Glamorgan.
• There is currently a lack of capacity to undertake more substantial work on the wider determinants of health with partners, such as improving housing and educational attainment, employment etc.
• There is currently a lack of investment in prevention: the Faculty of Public Health recommends 15 public health consultants for a population of 500,000, we employ 5.5 WTE.
 	
Risk: a deterioration in the wider determinants of health
 	
• Health inequalities are well documented across the UK and arise in three main ways:
  • structural issues e.g. income, employment, education and housing
  • unhealthy behaviours due to the environment, social norms and income levels
  • inequitable access to, or experience of, services, which can be a result of discrimination due to inaccessible services, public information or
	Potential impacts associated with this risk include:
	
	• Greater illness and poorer access to care (the inverse care law) will contribute to worse health outcomes. This impacts directly on the gap in life expectancy between the most and least deprived, resulting in a worsening of the gap in life expectancy and healthy life expectancy between different members of our population.
	
	• Health inequalities are already estimated to cost £3-4 billion annually in Wales through higher welfare payments, productivity losses, lost taxes, and additional illness. The total annual cost associated with inequality in hospital service utilisation to the NHS in Wales is estimated to be £322 million, equivalent to 8.7% of the total hospital service expenses, driven largely by higher service use among people living in the more deprived areas compared to those living in the least deprived (PowerPoint Presentation (nhs.wales). A lack of investment in prevention will cause an increase in future health service costs associated with health inequities.
	
	Potential impacts associated with mitigation of this risk include:
	
	• Taking action on health inequalities can reduce premature mortality, reduce social disparities, and reduce the absolute time in ill health for people in our communities. For example, using an NHS service such as ‘Help Me Quit’ can increase a person’s chance of successfully quitting. 'Help Me Quit' clinic provision is aligned with areas where smoking prevalence and deprivation are highest to help reduce barriers to service access.

Strategic Risks – Health Equity

healthcare sites that may be relevant/pertinent to particular needs. The 'Inverse Care Law' has been recognised for over 50 years, with those experiencing disadvantage consistently experiencing more challenges in accessing health services. Inequity of access to healthcare continues to be evident in Cardiff and the Vale of Glamorgan.

- There are significant inequities that impact the health of people in our communities. People in the most deprived areas die earlier on average and live more of their lives in poor health; this is well recognised and deeply entrenched, but it is preventable. Risk factors interact and multiple aspects of disadvantage come together, increasing the disease burden and widening equity gaps. Disadvantage experienced in childhood is often compounded and exacerbated through adult life and often passes inter-generationally. Examples of the impacts of these inequities on health include:
  - Areas with higher unemployment have greater incidence of suicide; and people living in the most deprived areas experience the largest increase in mental illness and self-harm.
  - In 2021 the *undiagnosed* diabetes rate was double for those in the bottom Index of Multiple Deprivation quintile compared to the top.This presents a challenge for the NHS in finding those with an unmet need for healthcare.
  - Lower levels of immunisation in the population have significantly increased the risk of outbreaks of diseases like measles. These will impact disproportionately more on our most deprived communities, with direct risks to health and by further negatively impacting on wider determinants such as education or employment.
  - In Wales in 2020-2022, 14.5% of deaths in adults aged 35+ and living in the most deprived areas of Wales were attributable to smoking, compared to 7.7% of those living in the least deprived areas. In Cardiff and Vale in the same period, 9.8% of all deaths in adults aged 35+ were attributable to smoking involving 5,573 admissions to hospital.

- Key population groups with multiple vulnerabilities include:
  - Some people in minority ethnic groups, especially some people in Black and Asian populations
  - People living in (or at risk of) deprivation and poverty
  - People in insecure/low income/informal/low-qualification employment, especially women.

- This can in turn reduce the burden on and costs to the Health Board and social care, while enabling our population to be more productive in our working lives. Spending on prevention has a superior return on investment when compared with acute hospital services. There is strong evidence that areas that invest more in prevention and community care see 15 per cent lower non-elective admission rates and 10 per cent lower ambulance conveyance rates together with lower average activity for elective admissions and EU attendances.

- Changing both the distribution of resources and the operating model to deliver preventative care closer to home will support the UHB to fulfil its organisational priorities as described in its Strategy, because they are derived from the changing needs of the population.

Strategic Risks – Health Equity

• People who are marginalised and socially excluded, such as people experiencing homelessness and other inclusion health groups			
Uncontrolled Risk			
Impact: 4	Likelihood: 4	Gross Risk: 16	Target Risk: 12

Controls	Assurances
1. Statutory duty • The Health Board has a statutory duty: to improve the health and well-being of the local population. • The Socio-economic Duty places a legal responsibility on public bodies in Wales when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. • **2. Role as an Employer** • In our Equality, Inclusivity and Human Rights Policy, we have an active programme, which sets out the organisational commitment to promoting equality, diversity and human rights in relation to employment, and ensuring staff recruitment is conducted in an equal manner. • Our Strategic Equality Objectives and Plan 'Shaping our Inclusive Culture 2024-2028, has a number of key delivery objectives and is premised on the basis of embedding equality, diversity and human rights, and Welsh language, into UHB business processes. • All our Executives have taken up a leadership role as an Inclusion Ambassador covering different characteristics, including those specified in the Equality Act 2010. Staff have been signposted to resources to help them to cope with the cost-of-living crisis. • The Head of Equity and Inclusion is a member of the Public Sector Equality Network, improving the collaboration between public sector organisations in the area. The UHB also now has an Equity & Inclusion Manager, together supporting Clinical and Service Boards, including with awareness and training on completing Equality Impact Assessments. In February 2026, the local public health team recruited an Equity & Health Improvement Officer whose work cuts across the teams "Big 3" priorities – smoking cessation, vaccination and healthy weight. **3. Our Strategy and Plans** • The refreshed UHB Strategy 'Shaping our Future Well-being' shines a light on the issue of equity at the strategic level. • The Cardiff and Vale long-term public health plan 2024 – 2035 sets out how the UHB intends to achieve its ambitions of increasing life expectancy, reducing inequity and shifting more focus to prevention.	Board papers Committee papers to Quality Committee e.g. updates on Equity, Equality, Experience and Patient Safety Framework. Committee papers to People and Culture and Quality and Safety Committees e.g. updates on Welsh Language Standards. Risk Registers Integrated Performance Report Papers to SLT

Strategic Risks – Health Equity

- 'Shaping our Inclusive Culture 2024-2028' is closely aligned with the UHB Shaping our Future Well-being.
- The refreshed UHB Strategy 'Shaping our Future Well-being' shines a light on the issue of equity at the strategic level.
- The Cardiff and Vale Long-term Public Health Plan 2024 – 2035 sets out how the UHB intends to achieve its ambitions of increasing life expectancy, reducing inequity and shifting more focus to prevention.
- 'Shaping our Inclusive Culture 2024-2028' is closely aligned with the UHB Shaping our Future Well-being.
- Through our PSB and RPB plans we already prioritise areas of work to tackle inequalities and the refreshed needs assessments for both PSBs and RPB have further identified collective actions.
- The future UHB organisational direction agreed at the recent rapid planning event supports the 'shift upstream' by committing to develop an Integrated Community Health System, underpinned by care pathways that begin with prevention; prevention is a 'brilliant basic'. An 'Equity, Equality, Experience and Patient Safety' action plan was approved by Board in May 2024, covering 24 initial actions across the Clinical Boards that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. Progress on actions is reported to Quality Committee on a 6-monthly basis (most recent update provided in February 2026). Ongoing review is undertaken to identify outstanding actions and create future actions using the framework.
- The Health Board is continuing to implement and periodically review its strategy to tackle the lower and unequal uptake of vaccination in our most deprived communities, using an intelligence driven approach and involving targeted, behaviourally informed communications and engagement.
- The establishment of a Strategic Diabetes Programme Board is a key element to reducing health inequalities and has an aim to identify those with undiagnosed diabetes in areas of deprivation across Cardiff and Vale.
- The Health Board has developed a co-ordinated programme of action to reduce smoking in areas/populations where prevalence is highest. It has also taken strong action to introduce enhanced enforcement of no smoking legislation on hospital sites across Cardiff and the Vale of Glamorgan, including introducing innovative approaches that are evidence based but have not been delivered in Cardiff and Vale previously.
-
- Through our PSB and RPB plans we already prioritise areas of work to tackle inequalities and the refreshed needs assessments for both PSBs and RPB have further identified collective actions.
- The future UHB organisational direction agreed at the recent rapid planning event supports the 'shift upstream' by committing to develop an Integrated Community Health System, underpinned by care pathways that begin with prevention; prevention is a 'brilliant basic'.

4. Public Health Priorities to reduce health inequalities.

The Public Health Team have agreed three immediate priorities that will influence health inequalities (and other work that we will need to bring forward when capacity allows). Work to tackle inequalities needs to take place over prolonged time periods. We continue to work with PSB and RPB partnerships to address the three priority areas where we know we can make a significant impact on reducing health inequalities: smoking, vaccination and obesity. The Amplifying Prevention Board, held jointly with Local Authority (LA) partners, provides

governance oversight of this collective action and works to remove any blocks to collective action The priority areas are: - preventing obesity (focus 0-5 years) - reducing smoking rates - increasing levels of vaccination (using an outreach model to reduce inequity in uptake). **5. Work to support health equity through greater patient engagement and feedback** The All-Wales Peoples Experience Framework was launched in April 2025 with ongoing work on implementing its recommendations. There are now several methods being used to gather feedback with the aim of ensuring all patients can contribute (available from the Patient Experience SharePoint pages). Training tools and guidance are also now available to support staff in engaging more effectively with patients and service users, helping them gather meaningful feedback about their experiences. These are complemented by monthly feedback-in-focus sessions held across sites to support patients, staff and carers in completing and understanding the many ways we collect feedback, offering support where needed. Translation and Interpretation pages, have also been developed in line with the Welsh Government Accessible Standards Framework, launched in September 2025, with ongoing work to raise awareness of the standards internally.	
Gaps in Controls	**Gaps in Assurances**
There is an ongoing need to improve the routine collection of protected characteristics to support the introduction of new indicators. This will need to be addressed by each Clinical Board.	The lack of monitoring data (e.g. on protected characteristics). A Population Health Management System to reduce inequalities by identifying those at risk. The ability to share information between Health Board teams on patient characteristics.

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

Actions			
What	**Lead**	**By**	**Update**
Within the UHB and through our PSB and RPB partnerships, continue to develop and deliver a	Claire Beynon	March 2026 with further	• Work continues to support data availability, linkage and analysis. A new action includes creating and developing an equity indicator dashboard. The next update on this work will be presented to the QSE in a further 6 months.

suite of focused preventative actions to tackle inequalities in health.		annual actions 2026/2027	• Smoking is a major contributor to health inequalities; smoking prevalence is typically higher in areas of greatest deprivation and has a significant influence on morbidity and mortality. Using an NHS service such as 'Help Me Quit' can increase a person's chance of successfully quitting by 3 times. 'Help Me Quit' clinic provision is aligned with areas where smoking prevalence and deprivation are highest to help reduce barriers to service access. Further work is also planned to improve outreach e.g. with housing association tenants. • Additionally, the Health Board has taken strong and decisive action to introduce enhanced enforcement of no smoking legislation on hospital sites across Cardiff and the Vale of Glamorgan; this is helping to protect vulnerable people. • Alongside more traditional advertising methods, innovative approaches to promoting 'Help Me Quit' are being trialled, including digital advertising in Cardiff city centre, 'in app' advertising direct to mobile devices, and partnerships with Cardiff City and Barry Town football clubs. In addition, the 'Help Me Quit' community service is working in partnership with local primary care practices and networks to take targeted action in deprived areas to promote smoking cessation services and encourage referrals and uptake amongst high-risk patient groups such as those with chronic respiratory diseases. Completed: • Across the UHB, work continues to meet targets in the existing Equity, Equality, Experience and Patient Safety Plan, especially in relation to data collection to support data availability, linkage and analysis. A new action includes creating and developing an equity indicator dashboard. The most recent updates on this work were presented to the Quality Committee. • Papers have been taken to the RPB and PSB on health inequalities, such as the annual Director of Public Health Report and the Population Needs Assessment. These highlight the issue of health inequalities and workshops have been held, e.g. diabetes deep dive, child health deep dive to highlight inequalities and develop collective actions to reduce these. New actions: • Continue to provide feedback via the Quality Committee on the new actions identified in the Equity, Equality, Experience and Patient Safety Framework and Action Plan. • Write an Annual Director of Public Health report that highlights health inequalities and actions to take to reduce these. • Refresh sections of the Population Needs Assessments or undertake Health Needs Assessments for the population that highlight health inequalities and actions that can be taken to reduce these and share these with appropriate partners (e.g. RPB and PSB) • Refresh the UHB's Vaccination Equity Strategic Plan and embed equity as a cross-cutting theme in strategic action plans to address vaccination uptake in childhood, teenage and adult populations. • Ongoing work has started in partnership with CONVO (online video interpreting service) and the BSL (British Sign Language) community to improve equality of access within our health services. This includes

Strategic Risks – Health Equity

			adding a video relay service to our main telephone lines and a pilot project allowing BSL to book their own interpreter via WITS (Wales Interpretation and Translation Service).
Advocate for more resources for prevention as a percentage of the total health board budget.	Claire Beynon	2026/2027	• Continue to advocate for increased resources for prevention to improve the health and well-being of the local population. • Keep working on the business plans that would allow full implementation of evidenced based interventions to reduce health inequalities for smoking and obesity, to include time frame for benefits. • Suggest a methodology that supports the collection of data on spend on preventative activities, with a focus on primary prevention.
Improve the routine data collection in relation to equality and inequity across the UHB.	Claire Beynon	2026/2027	• Follow the advice and guidance from the internal audit on data collection on protected characteristics once report is finalised. • Request further analyses of aspects of access to health services by Welsh Index of Multiple Deprivation. • Expect Clinical Boards to take responsibility for understanding their data in relation to protected characteristics, and to take positive action in relation to this.

Strategic Risks – People

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
People	Shaping our People and Culture	Rachel Gidman	People and Culture	Revised 01/05/26

Risk

If we do not secure and sustain a capable, sustainable and engaged workforce with the right skills, capacity and working environment, we will be unable to maintain services and deliver the required transformation for the population we serve.

Cause	Impact
Workforce Sustainability **a) Workforce supply and capacity (recruitment, retention, skills)** • Workforce planning not aligned to demand and capacity (activity planning). • Inconsistent workforce planning capability, confidence and capacity among managers; variable use of tools, scenarios and establishment data to inform decisions. • Workforce plans are not consistently aligned to future service models, productivity assumptions and population need, increasing reliance on short-term mitigations. • Limited capability, capacity to redesign our workforce as we continue to follow traditional workforce models instead of pathway and skills-based approach. • Limited triangulation of workforce, quality, demand and finance data to identify emerging capacity hotspots and future sustainability risks early. • Long term gaps in hard-to-recruit, critical and specialist roles, creating fragility in services and limiting flexibility. • Governance/compliance pressures (ESR/data quality, establishment control, safer staffing, mandatory training, professional registration, legal compliance) divert capacity and can expose gaps if not consistently managed. • Limited alignment between education, training, talent development and future workforce requirements, reducing the strength of the workforce pipeline, succession planning and future capability. **b) Workforce productivity and deployment (rostering, job planning, bank/agency optimisation)** • No unified E-Rostering system for all staff groups reduces productivity and limits the ability to redeploy staff safely and in a timely way. • Variation in roster compliance impacting delivery of agreed KPIs. • Job planning not aligned to capacity and demand planning.	• Quality, safety and continuity of care may be compromised, including increased risk of clinical errors, reduced team effectiveness, impaired decision-making, reduced patient experience and reduced ability to maintain safe services under sustained pressure. • Strategic priorities, improvement and future service models may be delayed or not delivered due to insufficient capacity, capability and engagement to support transformation. • Workforce sustainability, morale and engagement may deteriorate leading to increased sickness absence, fatigue and burnout, reduced productivity and increased risk to staff wellbeing and patient safety, with disproportionate impact on some staff groups and services • Financial sustainability and operational performance may be adversely affected through increased temporary staffing costs, inefficient deployment. • Organisational reputation, workforce equality and credibility as an employer may decline, including widening inequalities in staff experience, opportunity and outcomes (e.g. disciplinary processes, progression and pay), impacting trust, engagement and the ability to attract and retain staff in critical roles.

Strategic Risks – People

- Temporary staffing is not always optimised (bank fill, booking controls, rules), increasing cost and operational risk.

c) Workforce affordability (pay bill, agency, variable pay)

- Over reliance on agency and variable pay to maintain appropriate staffing levels.
- Pay bill controls and affordability constraints limit recruitment and capacity to grow priority services/future workforce.

d) Sickness absence and wellbeing-related capacity loss

- High and/or persistent sickness absence reduces available capacity and resilience, increasing pressure on remaining staff and creating demands for cover at short notice.
- Reliance on temporary staffing and additional hours to mitigate short-term gaps can worsen affordability and reduce continuity of care.

Culture, leadership, wellbeing & workforce experience

- Limited integration and triangulation of workforce, culture, wellbeing and EDI data reduce the organisation's ability to identify emerging risks early and take targeted action.
- Absence of clear, organisation-wide leadership and management expectations and standards, resulting in inconsistent behaviours, decision-making and accountability across services.
- Variability in management capability and confidence to lead teams effectively under sustained pressure, impacting staff experience, performance and retention.
- Psychological safety, dignity and respect concerns affecting staff wellbeing, willingness to speak up and organisational learning.
- Cultural signals (staff feedback, engagement data, incidents and ER themes) are not consistently triangulated and used to proactively identify and respond to emerging risk.
- Wellbeing model is predominantly reactive, with limited organisational-level preventative interventions embedded within service delivery and management practice.
- Sustained pressure impacting staff wellbeing, morale and engagement, increasing the risk of burnout, absence and disengagement.
- Inequity in workforce experience and outcomes, including disproportionate disciplinary processes, variation in access to development and progression, and differential experience across staff groups.

Strategic Risks – People

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

Controls	Assurances
Overarching: • People & Culture Plan embedded in the UHB. • Workforce Planning Training commenced. • Annual Plan with key deliverables, supported by Clinical Board delivery plans. • Speak up Safely system, SUS. • Clinical Board/CEF – bank and agency reduction plans • Strategic plans aligned to EDI priorities. • Medical & Dental workplan. • Temporary pay controls. • Managing attendance at work policy and training. **Domain 1 Controls: Workforce Sustainability** • Nursing staff in post forecasting and safer staffing processes to identify capacity risk, support escalation and inform plans. • Recruitment, onboarding and retention approaches, including values-based recruitment and use of workforce data to inform interventions. • Workforce planning and workforce-related risks reviewed through the IMTP and Annual Plan processes, with alignment to service priorities and escalation of material risks through executive and committee governance. • Improved education commissioning process. • Bank and agency governance/controls to manage use, authorisation and cost, supporting affordability. • Sickness absence case management, OH/EHWS support and return-to-work processes to protect capacity and wellbeing. • Education, training and talent development pathways, supporting workforce pipeline, succession planning and future capability.	Overarching: **People and Culture Committee** provides assurance to the Board through regular review of workforce, culture and wellbeing risks, including scrutiny of performance, delivery and emerging issues. **Monitoring of People and Culture Plan KPIs**, providing oversight of progress, risk trends and delivery against strategic priorities. **IMTP and Annual Plan reporting**, providing assurance that workforce risks, mitigations and delivery are aligned to organisational priorities and are escalated appropriately. **External assurance**, including Welsh Government oversight and performance reviews, providing independent challenge on workforce and organisational performance. **Domain 1 Assurances: Workforce Sustainability** • Workforce data and reporting (including Nursing Staff in Post forecasting) providing assurance on vacancy levels, capacity, supply risks and emerging workforce pressures. • Recruitment, retention and workforce experience data, including exit questionnaires and new starter surveys, providing assurance on workforce pipeline, early attrition and retention risks. • Workforce planning and IMTP processes, providing assurance that workforce risks are identified, modelled and incorporated into service and financial planning. • Financial and workforce performance data, providing assurance on temporary staffing usage, affordability and workforce deployment efficiency.

Strategic Risks – People

Domain 2 Controls: Culture, leadership, wellbeing & workforce experience **Leadership & Culture** • Leadership development and OD interventions, supporting capability to lead teams effectively under pressure. • Raising Concerns / Speaking Up Safely framework, enabling staff voice and organisational response to risk. **Wellbeing** • Integrated colleague health and wellbeing model, including preventative, early intervention and specialist support. • Occupational Health and Employee Wellbeing Services, providing structured pathways for support and escalation. **Equality, Inclusion & Workforce Experience** • Strategic Equality Plan, Anti-Racist Action Plan and WRES, supporting identification and action on inequities in workforce experience and outcomes. • Welsh Language Standards, supporting equitable access and inclusive workforce and patient experience. **Engagement & Insight** • Staff survey and engagement mechanisms, informing organisational understanding of staff experience and culture. • Use of workforce, wellbeing, ER and engagement data, supporting identification of cultural and wellbeing risks and targeted intervention.	**Domain 2 Assurances: Culture, leadership, wellbeing & workforce experience** **Leadership & Culture Assurance** • Staff Survey and staff engagement data, providing assurance on leadership, psychological safety, dignity and respect, with trend analysis over time. • Employee relations data and themes, providing assurance on behavioural issues, team functioning and emerging cultural risks. • Speak Up / Work in Confidence data, providing assurance on staff voice, responsiveness and organisational learning. **Wellbeing** • Occupational Health and Employee Wellbeing Service data, including demand, waiting times, high-risk cases and outcomes, providing assurance on workforce wellbeing pressures and access to support. • Sickness absence data (including stress-related absence), providing assurance on workforce wellbeing, capacity and organisational risk. **Equality & Workforce Experience Assurance** • WRES, Strategic Equality Plan and Anti-Racist Action Plan reporting, providing assurance on inequities in workforce experience, opportunity and outcomes. • Analysis of differential workforce experience, including disciplinary processes, progression and access to opportunity across staff groups. **Triangulated Insight** • Increasing use of triangulated workforce, culture, wellbeing and EDI data, providing assurance on early identification of risk, hotspots and targeted organisational response.
Gaps in Controls	**Gaps in Assurances**
Workforce Sustainability • No consistently applied, organisation-wide workforce planning standard (expectations, tools, scenarios, roles and governance) across all staff groups. • Variable capability and time to plan means workforce decisions can remain reactive, with inconsistent use of workforce insight to inform sustainable options. • Controls are stronger for nursing than for medical, AHP, support and corporate workforces (e.g., forecasting, establishment control, safer staffing equivalents).	**Workforce Sustainability** • Limited assurance on the quality, consistency and use of workforce plans (service/divisional/organisational) to inform decision-making and mitigation. • Assurance is weighted to current-state metrics; limited forward-looking assurance on medium/long-term sustainability, assumptions and scenario impact. • Assurance is stronger for nursing than for other staff groups; limited consistent assurance suite for medical, AHP, support and corporate workforces. • Limited assurance that sickness absence controls are reducing organisational risk over time (outcome-focused measures and evaluation).

Strategic Risks – People

• Inconsistent controls to reduce reliance on short-term mitigations (agency, overtime, goodwill) through sustainable supply, retention and productivity interventions. • Sickness absence controls are more focused on case management than on prevention and system-level interventions to reduce underlying causes. • Digital, automation and role redesign opportunities are not yet embedded consistently into workforce planning and productivity assumptions. • National workforce shortages and external labour market conditions constrain the effectiveness of local controls, increasing residual risk in critical roles. • Sustained operational pressure increases demand for cover, stressing existing controls. • Talent management and succession planning for critical roles is not consistently defined, limiting ability to manage future capability risk.	• Limited assurance on effectiveness of actions to reduce reliance on temporary staffing beyond activity/cost monitoring. • Limited assurance on the extent to which digital capability and automation are being used to support workforce sustainability, productivity and role redesign.
Domain 2: Culture, leadership, wellbeing & workforce experience **Leadership & Culture** • No agreed organisational leadership and management principles, resulting in variable expectations, behaviours and accountability across the organisation. • Limited controls to ensure consistent management capability, particularly in leading teams under sustained pressure and supporting staff wellbeing as part of day-to-day management practice. • Absence of an organisational cultural dashboard, limiting the ability to monitor cultural risk, psychological safety and leadership behaviours in a structured and timely way. **Wellbeing** • Wellbeing model is predominantly reactive, with limited organisational-level preventative interventions embedded within service delivery and management practice.	**Domain 2: Culture, leadership, wellbeing & workforce experience** **Leadership & Culture** • Limited assurance on leadership and management capability at scale, beyond staff perception measures, including confidence that managers are consistently equipped to lead teams effectively under sustained pressure. • Limited assurance that cultural risks are identified early, due to the absence of a structured organisational cultural dashboard or equivalent mechanism. Insight and Early Warning • Limited triangulation of workforce, culture, wellbeing and EDI data, reducing confidence that emerging risks and hotspots are identified and addressed proactively. **Wellbeing** • Limited assurance on the effectiveness of wellbeing controls, with assurance currently focused on service activity and demand rather than preventative impact or outcomes. • Equality & Workforce Experience

Strategic Risks – People

• Increasing demand and complexity within Occupational Health and Employee Wellbeing Services, indicating pressure on existing controls and risk of reactive service provision. • Limited organisational controls to address sickness absence at a structural level, with greater emphasis on case management rather than prevention. • Lack of an agreed organisational Colleague Health and Wellbeing Framework, reducing clarity and consistency in how wellbeing is prioritised and embedded. **Workforce Experience, Access & Inclusion** • Inconsistent communication and access to information and support, particularly for non-digital staff groups, increasing risk of exclusion and disengagement. • Variable awareness of, and access to, wellbeing and support services, limiting effectiveness of existing interventions. • Inconsistent clarity of support pathways, increasing the risk that staff and managers do not access appropriate support at the right time. • Inequity in workforce experience and outcomes not fully addressed, including variation in access to development, progression and experience across staff groups.	• Limited assurance on differential experience and outcomes across staff groups, including the ability to identify and respond to inequality-related risks in a timely and systemic way.

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

Actions			
What	**Lead**	**By**	**Update**
Agree and publish an organisation-wide Workforce Planning Framework (scope, required inputs/outputs, templates, scenario rules, governance/approvals, annual cycle and escalation), plus additional targeted short training/implementation plan for managers.	Donna Davies	Sept-26	

Shaping Our Future Wellbeing

Strategic Risks – People

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

Medical & Dental workforce deployment, including implementation of a unified E-Rostering system, robust job planning, implementation of the Welsh Resident Doctor Contract (WRDC), etc	Martyn Capel	Aug-26 (phase 1)	
Continue to reduce the reliance on temporary workforce through agency and bank reduction & improve monitoring through development of a dashboard.	Lianne Morse	Mar-27	
Strengthen leadership accountability and early intervention through a consistent, data-led attendance management and wellbeing approach to sustainably reduce sickness absence.	Katrina Griffiths	Mar-27	
Develop and implement organisational leadership and management standards, including defining how capability will be assessed and assured at organisational level in collaboration with HEIW national work.	Claire Whiles	Mar-27	
Develop a proportionate organisational cultural dashboard, drawing on existing data sources, to support early identification and monitoring of cultural risk.	Claire Whiles	Aug-26 (phase 1)	
Redesign and implement an organisational wellbeing model to ensure appropriate balance between preventative, early intervention and specialist support.	Claire Whiles	Sept- 26	
Transition from WTD% payments to AfC Average payments, aligned to national programme of work to ensure the UHB are legally compliant.	Lianne Morse	Mar-27	
Organisational readiness for the new Future Workforce Solution (replacement for ESR), prior to implementation	Lianne Morse	Dec-26	

Strategic Risks – Digital

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

Risk

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

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

Strategic Risks – Digital

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

Controls	Assurances
• Digital strategy approved by Board in 20/21 with roadmap for 21/22/23 - these will be refreshed by April 2025 • Roadmap to support the strategy shared with DHIC covering 2024/27 - these will be refreshed by April 2025 as part of the Digital Foundations PBC work • Digital components described in IMTP – focussed on in year national and clinical board priorities • £466K is being invested by CAVUHB in the development of a Digital Programme Business Case (PBC) to seek All Wales Major Capital Funding alongside a Business Justification case (BJC) for phase 1 of the 5 annual phases. This work will complete in 12 months. • The work will deliver a clear trajectory, costs and plans on how CAV will achieve its target of HIMSS[1] Level 3 in pursuit of its intention towards a modular EPR, consistent with national and regional initiatives. The capabilities the PBC and business justification cases will describe are harmonious with and would segue into any nationally agreed and funded EHR solutions through interoperability and concordance with the "All Wales" Infrastructure review. ○ Work is expected to begin Oct/Nov 2024. ○ This follows positive discussions with WG IIB and NHS CDIO,	• All Controls are shared and discussed with the DHI Committee which meets quarterly. • The Digital Foundations case was scrutinised and approved by the Investment Group and Strategic Leadership Board. • The Director D&HI shared the intentions of the Digital Foundations investment case and updated WG's chief digital officer, whilst the DoF has discussed with IIB Lead. Both are supportive of approach and our intentions • Recruitment and procurement is underway for the resource to produce the PBC and BJCs • Risk register articulates the risks of not being able to deliver digital solutions to support delivery of healthcare (1) • Internal audit report highlights the risk in delivering digital strategy citing the investment challenges that will prevent full implementation.
Gaps in Controls	**Gaps in Assurances**
Current annual discretionary funding is insufficient to cover the maintenance upkeep of the core infrastructure and there is no headroom for innovation	Unable to currently provide assurance that the finance will be provided

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

Strategic Risks – Digital

Actions			
What	**Lead**	**By**	**Update**
Internal investment case to support the Digital Foundations case approved	Director of DHI	Mar 26	Programme Business Case completed and shared with WG setting out detailed roadmap plans and the associated costs, funded accessed by annual Business Justification Cases to WG's Major capital budget. Statement of works produced against which a suitable external partner will be sought Digital Foundations Programme Business Case and supporting Business Justification Cases for Year 1 (of the 5 year case) complete. PBC being taken through the internal governance process comprising Capital Management Group, Value & Benefits Realisation Group, Senior Leadership Team, F&P and D&I committees before presenting to the November Board meeting and thereafter submission to Welsh Government for their consideration/approval. The existing Digital Foundations PBC seeks funding from the all Wales major capital budget but has a revenue tail which is currently unfunded. additional work is taking place, including detailed discussion with each Clinical Board, to idenitfy the funding source to enable the PBC to progress through internal CAV UHB governance process – this will likely not happen until the new financial year. May 26: Meeting with WG's Head of Capital, CAV DoF and CAV DoD took place on 13/05/26 to provide update and share summary information in advance of a formal submission if and when agreed by CAV Board following due governance process.
Development of the Digital Programme Business case to support the digital foundations ambitions is underway.	Director of DHI	May 26	External partner identified and service procured which has enabled the works to commence on the Programme Business Case. Co-production approach with all Clinical Boards and corporate services involved via workshops taking place during May and June 2025. July 25: Draft plans and outputs from workshops shared with Clinical Boards for comment prior to feeding into the Programme Business Case in Sept/October 25. Digital Foundations work to support the development of the Programme Business Case and supporting Year 1 Business Justification Cases complete. Workshops held with input from all Clinical Boards and services to ensure full co-production and alignment with the organisation's strategic objectives. Nov 25: Further scoping and detailed workshop being held with each Clinical Board during November and December to capture the detail of where savings can be made arising from automation and digital changes which will be used to off-set the revenue shortfall. The DF PBC has been shared with digital team at WG following the Digital presentation made at the November IQPD meeting. The intention is to submit the final case to Board for approval prior to formally submitting to WG for consideration via the Infrastructure Investment Board Jan 26 – additional work to identify the funding source for the asociated revenue costs – especially in year 1 of the PBC means that the process will slip into 26/27. Decisions on allocating WG major capital are not expected until well into Qtr 1 26/27. May 26: An updated PBC and Year 1 BJCs have been developed and are in the process of working through the internal governance process having been reviewed by the D&I committee, SLT and Value & Benefits

			Realisation Group and Capital Management Group, with the case to be considered at the Finance & Performance Committee prior to submission to Board on 28/05/26.

Strategic Risks – Infrastructure

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

Risk

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

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

Uncontrolled Risk

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

Strategic Risks – Infrastructure

Controls	Assurances
• Estates strategic plan in place which sets out how over the next ten years, plans will be implemented to secure estate, which is fit for purpose, efficient and is 'future-proofed' as much as possible, recognising that advances in medical treatments and therapies are accelerating. This will be updated following the conclusion of the conditions survey, clinical services plan and the site masterplanning work. • Statutory compliance estates programme in place• The strategic plan sets out the key actions required in the short, medium and long term to ensure provision of appropriate estates infrastructure. • The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP/annual plan, with regular oversight of the programme of discretionary and major capital programmes. The 2026/27 Capital Plan will be submitted for Board with the Annual plan • Medical Equipment prioritisation is managed through the Medical Equipment Group and there is a process in place for rapid decision making if there is a urgent need to replace a piece of equipment. This is managed within the remit of the Capital Management Group. • Business Case production or delivery is managed through the Capital Management Group/Investment and benefits realisation group . • • Welsh Governments stated priorities are Theatres including Vascular/MTC theatres, Haematology including BMT and ITU refurbishment. • Welsh Government has agreed regarding the Shaping Our Future Acute Hospital Programme a series of activities which will support the Health Board to refresh it's estates strategy.	• The Health board teams including estates and capital team work with Welsh Governmentto identify opportunities to improve the estate sustainability and manage any emergent or urgent risks.• The statutory compliance areas are managed and monitored within the Health Board• • the Capital Management Group, Senior Leadership Team the Digital and Infrastructure committee and Finance & Performance Committee
Gaps in Controls	**Gaps in Assurances**
• The current annual discretionary capital funding isinsufficient tomeet all the priorities identified through risk assessment, Annual Plan and Strategic ambitions of the organisation.• further impact the teams and resources available • Traceability of Medical Equipment • The Welsh Government capital funds are insufficientto meet the capital requirement	• the regular statutory compliance surveys remedial works • • • .

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

Strategic Risks – Infrastructure

Actions			
What	**Lead**	**By**	**Update**
Infrastructure risk management	Geoff Walsh		Vision document to be Board approved in Q2 26/27 to submit to Welsh Government for the future of critical services at UHW to include BMT, ITU and theatres BMT JACIE accreditation service delivery business case ITU refurbishment business case Theatres refurbishment business case Ophthalmology theatres business case To be approved by the Health Board and submitted for funding to Welsh Government in 2026/27 Commencement of the Park View (Ely) health and wellbeing centre infrastructure project in Q1 26/27 Capital management group to oversee a review of medical equipment risk across the assets and support the development of a management plan Q4 26/27 Work with Welsh Government to highlight and mitigate risks and opportunities to manage infrastructure issues in a proactive and sustainable way.
Estate utilisation a programme of decommission, disposal or demolition is undertaken to minimise the estate and infrastructure which the Health Board needs to maintain.	Geoff Walsh	As per individual actions	Decommission priorities – Denbeigh and Carmarthen house have been vacated, and planning permission is being sought for their demolition, along with Brecknock House and the recently vacated Sports and Social club. Delivery Quarter 3 26/27 Disposal plans – Rookwood the UHB are working with the successful bidder to achieve conditional sale May 26. Clinical service plans are being developed for the future of the ALAS and other Rookwood legacy services as well as Treforest. These are expected to be in place with a site solution by Q4 26/27 Education and clinical service plans are being developed with Cardiff University to develop a future model of delivery for dental education, training and service provision. Q3 26/27 Estates planning around the Dental Hospital will be undertaken in light of the future model. From Q4 26/27. Decommissioning of the Tenovus building in conjunction with Cardiff University

Strategic Risks – Infrastructure

Condition Survey	Geoff Walsh		Develop a management and action plan for the results of the condition survey in two parts, firstly the highest risk issues (Category D & Dx) and then for all other issues identified in the survey. Highest risk management plan to be approved in Q2 26/27. Whole report management plan to be developed in following 9 months and used to inform the 27/28 capital programme for Welsh Government and the Health Board.

Strategic Risks – Sustainability

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

Risk

Decarbonisation and Climate

If the organisation cannot protect the environment and take the steps required of it regarding waste, carbon footprint and other deliverables, it will not be an efficient service and will jeopardise the health of future generations.

Finance

If the organisation cannot deliver a financially sustainable position or demonstrate the required progress toward strengthening financial control and prioritisation, it will remain in Targeted Intervention and be unable to meet Welsh Government expectations or deliver its strategic objectives. Quality of care will ultimately be impacted.

Cause	Impact
Decarbonisation and Climate	
The world has breached the 1.5°C pathway set by the Paris Agreement in 2024. Growing evidence shows that the magnitude of climate impacts is increasing day by day, and Cardiff is projected to be one of the most affected cities in the UK.	Initial findings from our ongoing heatwave survey reveal that **80% of staff reported high levels of discomfort, with 32% experiencing health effects during recent heatwaves**. Preliminary analysis of climate data also indicates a projected increase in the frequency and intensity of heatwaves. These figures underscore the urgent need to protect our workforce and adapt our care environments to ensure resilience in the face of escalating climate risks. Initial findings from the heatwave survey indicate a **~30% of clinicians have observed an increase in patient footfall during and immediately after heatwave periods**. Additionally, there were reports of extended patient length of stay, attributed to poor rehabilitation outcomes and delayed recovery. Both of the above factors present a financial risk.
In 2024-25 the UHB's emissions increased by 44% to c260,000 Tons of Co2 compared to 2023-24 emission of c180,000.	The UHB has already missed Welsh Government target of reducing its emission by 16% by 2025.

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Currently, UHB has undertaken an initial climate risk assessment however a comprehensive assessment of current and future climate risks is yet to be conducted. CAV UHB has limited resource for Sustainability and Climate response.	CAV UHB does not have a line of sight to achieve the 40% reduction in directly controlled emissions required by the strategy by 2027 nor the 34% emission by 2030. (from a 18/19 baseline). This renders UHB vulnerable to unidentified climate risks that have a direct impact on healthcare delivery and its financial situation. This will impact on embedding sustainability and building climate response.
Finance	
The conditions required to stabilise the financial position are not yet in place. The organisation does not currently have a sustainable medium-term service/financial plan, and recurrent cost growth continues to exceed available resources. Collectively this includes: Planned deficit of £56.2m in 2025/26 with no identified recurrent route to balance. Recurrent cost growth (pay, workforce, drugs, CHC, demand pressures) outpacing allocation uplift. Limited progress to stop, reduce, or redesign low-value or unfunded services. High reliance on non-recurrent mitigations as part of savings plans. Growth in unfunded operational commitments. Underdeveloped internal commissioning and weak demand and cost control. Variable financial delivery and accountability across Clinical Boards. Planning cycles not grounded in realistic workforce, activity or cost parameters.	It is unlikely that the continuation of this situation will enable the delivery of the Health Board's objectives or meet Welsh Government expectations. The HB will need to demonstrate strengthened financial grip, consistent decision-making, and alignment between performance, workforce and resource allocation to de-escalate from targeted intervention. The collective impact may be: Breach of statutory financial duty. Continued or escalated NHS Wales intervention. Inability to invest in service redesign, digital, estates or workforce. Requirement for short-term corrective action with potential impact on quality and performance. Reduced flexibility and organisational resilience. Loss of credibility with Welsh Government. Inability to deliver the Health Board's strategy.

Strategic Risks – Sustainability

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

Controls	Assurances
Decarbonisation and Climate	
A decarbonisation action plan is in place to deliver decarbonisation actions aligned with the NHS Wales Decarbonisation Strategic Delivery Plan 2021-2030. SusQI has been implemented to embed sustainability in Q&I projects. The Welsh Government has mandated yearly reporting, such as Decarbonisation Co-Ordination Reporting and Emission Reporting, along with all other health boards in Wales. The Welsh Government has made it mandatory to report qualitatively on progress regarding climate adaptation. A task and finish group has been established to identify pathways for climate risk assessment and climate adaptation pathways. Initial conversations are being held with the MET Office to collaborate bid for external funding and conduct a comprehensive Multi-Risk Assessment, starting with the impacts of heatwaves and flooding on our operations.	Climate Response plan is under development and will be overseen by Finance and performance committee First Iteration of CAV UHB Climate Risk Assessment has been undertaken and a Climate Adaptation plan is under development. The identified risks will be uploaded in AMaT.
Finance	
Scheme of Delegation and financial governance framework for expenditure approval. Annual Operational Plan aligned to savings requirements and control totals. Savings Program monitoring through: – Senior Leadership Team – Monthly Executive performance reviews / Finance deep dives – CEO-chaired Financial Summits	Monthly financial reports and savings delivery updates to the Finance & Performance Committee. Board receives monthly Integrated Performance Report including financial risk assessment. Internal audit provides assurance on the adequacy of financial systems and controls.

Strategic Risks – Sustainability

Finance Business Partnering providing forecasting, reporting and corrective action support. Monthly Finance & Performance Committee scrutiny. Internal audit reviews of financial controls, planning and budget management. Workforce controls and recruitment approval processes aligned to financial plan compliance.	Welsh Government oversight through Targeted Intervention with regular feedback. Forecasts and financial deep-dives reviewed by SLT and Management Executive.
Gaps in Controls	**Gaps in Assurances**
Decarbonisation and Climate	
Given the complexity of decarbonisation actions across various departments of the UHB, there is a lack of continuous, robust monitoring. This would require the reestablishment of a digital climate change program dashboard, setting of qualitative and quantitative KPIs aligned with targets, and a seamless data collection process for all decarbonisation actions. Sustainability needs to be embedded in decision-making. The business plan template needs to capture sustainability from decarbonisation and climate risk perspectives and should be given appropriate weight. Climate Impacts needs to be included in appropriate risk registries, and risk thresholds needs to be set.	A working group or delivery group needs to be established, comprising staff who are owners of decarbonisation actions, to highlight progress and barriers.
Finance	
No approved medium-term financial strategy addressing the recurrent deficit. No formal decommissioning framework for low-value or unaffordable services. Internal commissioning and demand management not sufficiently developed. Structural savings pipeline incomplete and over-reliant on non-recurrent measures.	No independent validation of savings assumptions or deliverability. Insufficient triangulation of financial, workforce, activity and quality data. Improving but limited benefits-realisation reporting for previous investments.

Strategic Risks – Sustainability

Weak enforcement of accountability for non-delivery of financial targets. Decision-making not consistently aligned with affordability constraints.	

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

Actions

What	Lead	By	Update
The emission gap between the health board's current emission pathway and targets set by the Welsh government and the SOFW strategy is widening. Hence, the emission reduction targets, and pathway need to be reviewed.	Catherine Phillips	September 2025	A Sustainability Program Board has been established to review and monitor progress of decarbonisation actions.
The 25/26 Quality Improvement and Efficiency Plan has been developed as part of the 2025-26 financial plan	Catherine Phillips/ Paul Bostock	Ongoing during 2025-26 Financial Year	Clinical Board Performance Reviews and Deep Dives to drive QIEP delivery including the management of operational pressures with a greater focus on recurrent positions. A monitoring function for all plan aspects has been developed and is being utilised in the Finance & Performance Committees during 2025-26. The monitoring reports also support all other fora in which the QIEP delivery is being discussed and supported.

Report Title: *(needs to match agenda)*	Update on Fuller Report recommendations		Agenda Item No:		6.1
Meeting:	Quality Committee	Public	X	Meeting date:	30.06.2026
		Private			
Lead Executive Title:	Executive Director of Nursing				
Report Author/s Title:	Director of Nursing & Multi-Professional Teams Clinical Diagnostics & Therapeutics Clinical Board				

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)*

- 21 Recommendations in Report (yet to be fully agreed by Westminster Government)
- Gap analysis undertaken against 21 recommendations
- The paper provides an update to the position shared with SLT in February 2026**.**

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		**Approval**		**Information/Noting**	x

Recommendations

1. note the evidence of substantial progress against the 21 Fuller recommendations
2. acknowledge the residual risks relating to body storage capacity, capital-dependent security controls and safeguarding training.
3. confirm arrangements for future reporting into appropriate board committee
4. request a further update once capital estimates, winter capacity plans are confirmed.

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

Where *it's been:*	*SLT*
When *it went:*	*February 2026*
What *decision was made:*	*Recommended to come to quality committee*

Main Report

Background & Current Situation

Purpose
This report provides Quality Committee with an update on progress against the Fuller Inquiry recommendations relevant to NHS mortuaries and body stores, including the current compliance position, residual risks and actions required to complete implementation.

Background and scope
The Fuller Inquiry final report was published on 15 July 2025 and made 75 recommendations to strengthen the security and dignity of people after death across a range of settings. An interim update from Westminster Government on 16th December 2025 accepted 11 recommendations in full, 43 in principle and 21 under consideration with a final response planned for Summer 2026.
Recommendations 1–21 specifically relate to NHS mortuaries and body stores. And these have been approved in principle.
Recommendations 1–9 relate to the NHS estate. The remaining 12 recommendations focus on governance, accountability and safeguarding within NHS trusts.

Current position
Seven recommendations have been completed, with the remaining recommendations largely on track. Full implementation is dependent on continued support from Capital, Estates and Facilities, alongside changes to the All-Wales procedure. As part of phase one of the Inquiry, initial recommendations were shared with teams and incorporated into the UHW mortuary refurbishment programme, supporting progress against the final recommendations. The HTA inspection of the UHW and UHL mortuaries on 1 September 2025 provided positive assurance, with all HTA standards met.

Progress and assurance
Recommendations 3–7 relate to security systems and processes. There is good assurance and evidence that these recommendations are being met. CCTV is in place, and regular audits are undertaken to confirm that mortuary security arrangements prevent unauthorised access and provide oversight and recording of visitors with a legitimate right of access.
Recommendation 9 requires regular monitoring of mortuary access. The Designated Individual and Service Manager routinely review access permissions. TDSI access is reviewed quarterly, and access is revoked for individuals who have not accessed the mortuary during the previous quarter.

Outstanding actions and dependencies
For the NHS estate recommendations, the outstanding actions include upgrading TDSI access to require swipe-in and swipe-out and making further changes to CCTV coverage to comply with recommendations 1, 2 and 8.

Residual risks
Recommendation 17 requires the recommendations to apply to any temporary body stores. The decision therefore was taken to decommission the temporary body store at UHL. This has reduced winter capacity, and an additional capacity plan is being developed.
Recommendation 19 states that trust boards should ensure the security and dignity of the deceased are included in safeguarding training, policies and assurance processes. Compliance will require a change to the All-Wales Safeguarding Procedures.

Governance and reporting arrangements
Recommendations 15 and 18 relate to trust board reporting arrangements for mortuary services as a regulated area. The HTA Compliance Group currently reports into the CD&T Clinical Board QSE sub-committee. The annual CD&T QSE report would include any HTA-related incidents or inspections. Going forward, a formal report can be provided to Quality Committee to meet this recommendation.

Next steps

The next steps are to confirm capital estimates for the required access and CCTV changes, finalise the winter capacity plan, confirm the ongoing reporting route to Quality Committee and monitor national changes to the All-Wales Safeguarding Procedures.

Conclusion

Substantial progress has been made against the Fuller recommendations relevant to NHS mortuaries and body stores. The remaining areas are understood and are being progressed through estate-related actions, winter capacity planning, governance reporting arrangements and national safeguarding procedure changes. Continued oversight through quality committee could ensure that residual risks are monitored and that implementation remains aligned to the principles of dignity, security and accountability for people after death.

Appendices:

1. **Evidence, Gap Analysis and Actions against Fuller report recommendations document**
2. **Link to HTA Inspection report** HTA-TEM-017 Post Mortem inspection report template

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
Winter capacity plan requires work to identify additional space that is compliant with HTA and Fuller recommendations, as referenced above.
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Evidence, Gap Analysis and Actions against Fuller report recommendations (1 to 21) (2025)
Update 17/06/2026

A comprehensive gap analysis has been completed against the Fuller Report recommendations to assess current alignment and identify areas requiring further development.
The findings from this review have informed the creation of this Evidence of conformance record, Gap Analysis and action log, which outlines the targeted actions needed to close identified gaps.

Recommendation No.	Recommendation	Evidence of Conformance	Gap/action No	Gap	Action	Due date	Action lead	Updates (with date)	Status	Date Completed
1	**All NHS trusts with mortuaries and/or body stores should commission a specialist strategic review of the systems in place to protect deceased people, which should include a detailed risk assessment of the potential breaches of security that could occur. The review should include an assessment of:** **- the systems in place to identify any unauthorised access to the facility;** **- the strength and effectiveness of barriers to prevent unauthorised access to the facilities;** **- the systems in place to identify any access to deceased people for unauthorised purposes; and** **- how CCTV is used, including its**	1. A security review has been scheduled to be undertaken by the head and deputy head of security services 2. Access to the mortuary and body stores are controlled by TDSi card access, access is only granted by the DI and Service Manager as a PD 3. Access via a TDSi and via sign in logs is audited each month. TDSi badge access is reviewed each quarter with those not accessing being removed 4. CCTV is installed covering all access points and body storage areas. The images are available for monitoring on the Mortuary office screen the service managers screen and within the security office. Audits of access correlated to the CCTV are undertaken every 2 months across both UHW and UHL	**1.1**	Expert review not yet undertaken		Q1 26/27	SG	Completed on 25.2.2026	**Completed**	
			1.2	Physical lock of body store at UHW as contingency to TDSI failure	MR raised	Q4 25/26	SG	MR raised for physical lock	**On track**	
			1.3	TDSI lock changes to swipe in and swipe out of body store areas	To be discussed as part of security walk around	Q1 26/27	SG	Security review completed across all sites, requirement to add additional TDSI swipe access and additional CCTV camera's and physical locks- waiting cost estimate from CEF. Sspecification 3 weeks from 16th June, tender process 3 week with works taking further 2 weeks	**On track**	
			1.4	Expansion of CCTV at UHW to cover body store blind spots	To be discussed as part of security walk around	Q1 26/27	SG	Security review completed across all sites, requirement to add additional TDSI swipe access and additional CCTV camera's and physical locks- waiting cost estimate from CEF	**On track**	

	monitoring and any audits undertaken.		**1.5**	Expansion of CCTV coverage of body store at UHL	To be discussed as part of security walk around	Q1 26/27	SG	The temporary body store has been taken out of use as it is non confromant with the recommendations - 15/07/2025. This remains the case after the security review and will not be used	**Completed**	
2	**All NHS trusts should install CCTV inside the mortuary, with cameras facing all doors and access points, the reception area and the doors of body fridges, while maintaining the security and dignity of deceased people by implementing the appropriate safeguards. Where double-ended fridges also open into the post-mortem room, NHS trusts should install CCTV cameras inside the post-mortem room that focus on the doors to the fridges.**	1. CCTV is installed covering all access points and body storage areas. The images are available for monitoring on the Mortuary office screen the service managers screen and within the security office. Audits of access correlated to the CCTV are undertaken every 2 months across both UHW and UHL 2. Double ended fridges are built into the mortuary facility at UHW. The post mortem suite side doors are locked and sealed with tamper tape to prevent use. The placement of CCTV within the post mortem suite to monitor the fridges could not be done without compromising dignity of those undergoing post mortem examination. This approach was accepted by the HTA during last years inspection visit (01/09/2025)	***2.1***	Expansion of CCTV coverage to cover 'blindspots' in each area	To be discussed as part of security walk around	Q4 25/25	SG	The body store has been taken out of use as it is non confromant with the recommendations - 15/07/2025 Security review complete, cost estimate awaited for remedial and improvemnet works (TDSI swipe in and out - both sistes, Physical locks, additional CCTV coverage)	***On track***	
			2.2	Expansion of CCTV coverage of the temporary body store at UHL	To be discussed as part of security walk around Decommissioned	Q4 25/26	SG	The temporary body store has been taken out of use as it is non confromant with the recommendations - 15/07/2025 The body store is unsecurable in current location. Removed from service - risk for times of increased seasonal demand Alternate plan working up to cover 40 adult space defecit for winter 2026	***On track***	
		1. CCTV is installed covering all access points and body storage areas. The images are available for monitoring on the Mortuary office screen the service managers screen and within								

3	**All NHS trusts should routinely audit the access data of all facilities used to store deceased people.**	the security office. 2. Audits of access correlated to the CCTV are undertaken every 2 months across both UHW and UHL. 3. Audit reports, findings and corrective, preventative actions are manged using the Q-Pulse document management system. 4. Audit reports and findings are taken to the HTA compliance group.							**Completed**	01/12/2025
4	**The practice of using shared electronic swipe cards for specific staff groups should cease immediately.**	1. Access to the mortuary and body stores are controlled by TDSi card access, access is only granted by the DI and Service Manager as a PD 2. Access via a TDSi and via sign in logs is audited each month. TDSi badge access is reviewed each quarter with those not accessing being removed							**Completed**	01/12/2025
5	**All NHS trusts should consider putting in place systemic operational barriers that prevent the security and dignity of deceased people being compromised. An example of this would be implementation of a rule that prevents electronic devices such as phones or cameras being taken into a mortuary, other than for approved reasons.**	1. The mortuary team SOP states no electronic recording devices to be taken into the body store and PM suite. 2. Only mortuary staff have access to the PM suite. 3. Signage to be placed across the mortuary and body store areas for no mortuary staff	**5.1**	Signs ordered not yet sited	Signs to be placed when delivered	Q4 25/26	SG	Delivery due 04/02/2026 Signs applied 05/02/2026	**Completed**	05/02/2026
	All NHS trusts should take every breach of security in a mortuary or body store extremely seriously.	1. Mortuary security measures are described in a standard operating procedure. 2. All Identified security breaches would be raised on eDatix 3. All identified security breaches would be								

6	**Each security incident should be reviewed by a security expert who is able to identify any systemic security issues associated with the incident. A detailed action plan should be developed for each security breach, no matter how minor trusts regard such breaches to be. All security breaches occurring in mortuaries should be incorporated into security reports provided to trust boards or relevant subcommittees, in line with security breaches in other vulnerable areas.**	3. All identified security breaches would be raised as a Human Tissue Authority Reportable Incident (HTARI) in line with the licence requirements. 4. All HTARIs and Datix would require a full RCA to be undertaken. 5. The head of security services would be engaged to support the RCA and to challenge and test solutions. 6. All incidents are reported through the Cell Path HTA compliance group, minutes formally go through to the CD&T Regulatory Compliance Group, through to the CD&T QSE group and upwards to QSE committee and Senior Management Team and Corporate Licence Holder							**Completed**	24/12/2025
7	**The NHS should ensure that the security standards required for body stores are the same as those required for facilities licensed by the Human Tissue Authority.**	1. All locations storing deceased patients within C&VUHB are covered by an HTA licence. 2. The temporary winter pressures body store while on a licenced premise, is not conformant with the HTA standards consequently the unit is not in use, presenting a capacity risk.	**7.1**	The business continuity, temporary body store located at UHL is non conformant with HTA security standards and the requirements of the Fuller report recommendations	See previous actions	Q1 26/27	SL	Temporary body store removed from use permanantly Removed from service - risk for times of increased seasonal demand Alternate plan working up to cover 40 adult space defecit for winter 2026	**Completed**	
8	**All NHS trusts should consider the installation of 'swipe to exit' for mortuary facilities. This would allow trusts to monitor and audit entry and exit, as well as time spent in the mortuary.**	Access to body store areas is currently swipe in without a swipe out requirement. Time in the body store area is reviewed as part of the access and CCTV audits	**8.1**	TDSI lock changes to swipe in and swipe out of body store areas	To be discussed as part of security walk around		SG	Awiting cost estimate for remedial and additional works from capitla estates colleagues	**On track**	
9	**All NHS trusts should monitor the number of staff with access to the mortuary or body store and keep this under routine review.**	1. Access to the mortuary and body stores are controlled by TDSi card access, access is only granted by the DI and Service Manager as a PD 2. Access via a TDSi and via sign in logs is audited each month. TDSi badge access is reviewed each quarter with those not accessing being removed							**Completed** **Completed**	01/12/2025

10	**NHS trusts should ensure that Designated Individuals have enough time and resource to fulfil their responsibilities, including time for learning and development.**	1. The DI has allocated sessions to fulfil the responsibilities assigned through the HTA Act. 2. The DI has a number of Persons Designate to deliver actions and services under the Act, all of whom are accountable through the DI and HTA compliance Group							**Completed**	24/12/2025
11	**NHS trusts should ensure that senior managers, including the Chief Executive, have a clear understanding of the role of the Designated Individual, their lines of accountability, and the individual legal responsibility associated with being a Designated Individual.**	HTA compliance group meetings are minuted and reviewed by the CD&T Quality and Saftey Group. This group directly feed to the Quality Committee. All related auidts (CCTV, Access etc.) are fed to these groups.							**On track**	
12	**NHS trusts should ensure that Designated Individuals attend the correct governance forums. This would allow them to escalate issues and risks, as well as reporting upwards when required.**	1. The DI chairs the HTA compliance group 2. All incidents are reported through the Cell Path HTA compliance group, minutes formally go through to the CD&T Regulatory Compliance Group, through to the CD&T QSE group and upwards to QSE committee and Senior Management Team and Corporate Licence Holder	**12.1**	There is no formal direct report/communication between the DI and the corporate licence holder/responsible executive.	Discuss the formalisation of a DI and the corporate licence holder/responsible executive communication pathway	Q4 25/26	TH	HTA compliance group meetings, chaired by the DI, are minuted and reviewed by the CD&T Quality and Saftey Group. This group directly feed to the Quality Committee. All related auidts (CCTV, Access etc.) are fed to these groups.	**On track**	
13	**A professional background in the field of mortuary services should be made a prerequisite for the post of Mortuary Manager.**	1. The Service Manager acts as the mortuary manager. The individual has 33 yeas experience within mortuary services, including practical post mortem experience. The individual is a registered Biomedical Scientist, holds the Certificate in mortuary practice and is a Fellow of the Institute of Biomedical Science and an Affiliate of the Association of Anatomical Pathology Technologists undertaking CPD. 2. Mortuary Manager JD includes qualifications and experience as a requirement fro succesion planning							**Completed**	01/11/2025

14	**NHS trusts should assure themselves that the Mortuary Manager has adequate resources and support to perform their role effectively, including meeting any reporting requirements.**	The service is undergoing and OCP to develop an additional level of leadership within the mortuary team ,enabling effective and appropriate delegation of duties to ensure the service conforms with the HTA standards	**14.1**	Gap in leadership between the Service Manager/Mortuary Manager and the Anatomical Pathology Technologists, with inability to effective and appropriately delegate	OCP completion - Band 6 APT (Lead APTs roles)	Q1 26/27	SG	OCP documents completed (24/12/2025) Meeting with People services (04/02/2026)	**On track**	
15	**All NHS trusts should establish a routine reporting system for matters relating to mortuaries and body stores. This reporting system should include the presentation of a formal report, by the accountable executive director, to the trust board on a routine basis. The accountable executive director should prepare and present to the trust board a formal annual report, similar to the annual safeguarding report. The report should include:** **- staffing matters;** **- security incidents;** **- all serious incidents;** **- Human Tissue Authority reports (where applicable); and** **- all security audits, including audits of access and any access breaches.**	1. Issues are raised by CD&T SMT at Exececitive review meetings 2. Cell Path HTA compliance group, minutes formally go through to the CD&T Regulatory Compliance Group, through to the CD&T QSE group and upwards to QSE committee and Senior Leadership Team and Corporate Licence Holder	**15.1**	No formal report is provided	Formal report to be drafted and submitted to exec team	Q1 26/27	SG/TH	To present to Quality committee 30th June	**On track**	
16	**Trust boards should assure themselves that the recommendations in this Report have been implemented**	1. CD&T Briefing of Senior Leadership team 04/02/26 2. Formal report to be drafted and submitted to exec team		Formal report	Formal report to be drafted and submitted to exec team	Q1 26/27	TH/SG	To present to Qulaity Committee 30th June	**On track**	
17	**Trust boards should ensure that these recommendations and governance arrangements are**	1. Presentation to SLT of actions and position	**17.1**	Formal position presentation	Presentation to SLT	Q4 25/26	SG/TH	Presentation to SLT highlighting position against the 21 recommendations (04/02/2025). Paper to Qulaity committee 30th June	**On track**	

	applied to any temporary facilities used by trusts for the storage and care of deceased people.	2. Temporary body store UHL taken out of use as non conformant	**17.2**	Reduction in storage capacity	Development and agreement of capacity plan	Q1 26/27	TH/SH	Alternate plan working up to cover 40 adult space defecit for winter 2026	**Alert/Escalate**	
18	**Trust boards should take note of the fact that mortuary services are subject to statutory regulation and should be treated with equivalent regard to other regulated activities within trust governance arrangements.**	Cell Path HTA compliance group, minutes formally go through to the CD&T Regulatory Compliance Group, through to the CD&T QSE group and upwards to QSE committee and Senior Management Team and Corporate Licence Holder	**18.1**		Consideration of more structured route and formal report production	Q1 26/27	HL	Paper to Quality committee 30th June	**On track**	
19	**NHS trust boards should ensure that the security and dignity of deceased people are included in safeguarding training, policies and assurance.**	1) Local training and policies in place for mortuary team. 2) Level 1 safeguarding mandatory training in place for mortuary team (86% 6 from 7 complete)	**19.1**	One member of the mortury team not compoleted mandatory safeguarding training	Protected time allocated to undertake training	This week	SG		**Completed**	17/06/206
			19.1	No specific inclusion of dignity and security of deceased patients in safeguarding training	CB to discuss with safeguarding team, requires change to all wales safegurading procedures	Q1 26/27	HL	Requires update of All Wales Safeguarding Procedures	**Off track**	
20	**The remit of the Chief Nurse in NHS trusts should explicitly include executive responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores.**	1) Deceased patients remain in our care and afforded the same dignity and respect as the living. 2) The mortuary team offer the last care for the deceased whil ethey remain with us 3) Processes for security and dignity of the deceased in our care are Independently audited by the Cellular Pathology Quality team. 4) Audits, non conformances, corrective and preventative actions are managed through the Q-Pulse doument management system. 5 Audit reports are reported and discussed at HTA compliance group and minutes formally go	**20.1**	No specific route to EDON to provide assurance around safegurading the security and dignity of the deceased	CB to discuss with EDON route for assurance		HL	Security audits to be shared at SSG meeting on 15th September	**On track**	
21	**NHS England should formally incorporate the safeguarding of deceased people into its safeguarding framework for NHS trusts.**	NHS Wales consideration								

Report Title: *(needs to match agenda)*	Cardiac Implant Update			Agenda Item No:	7.1
Meeting:	Quality Committee	Public	X	Meeting date:	30.06.2026
		Private			
Lead Executive Title:	Chief Operating Officer				
Report Author/s Title:	Clinical Board Director, Specialist Services				

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 can take assurance that the Cardiac Device Service has moved from alerts and reactive risk management to a more structured and proactive operating model, with a number of controls and improvement actions now in place. These include SOPs and revised and improved systems and processes. There is strengthened governance, improved clinical oversight, digital transformation, validation of high-risk patient cohorts, and an ongoing workforce review, although continued monitoring is required to ensure improvements are fully actioned, embedded and sustainable.

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

Recommendations

a) Note progress made in reviewing the service and addressing patient safety risks.
b) Acknowledge ongoing system risks across workforce, governance and digitization and current mitigation in place.
c) Support continued transformation programme delivery.
d) Note progress with reviewing workforce models of delivery and demand/capacity review, digital transformation and administrative capacity, systems and processes.

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

***Where** it's been:*	*Specialist Services Clinical Board Executive Review*
***When** it went:*	*Various dates during 25/26*
***What** decision was made:*	*Formal presentation to Quality Committee*

Main Report

Background & Current Situation

The Cardiac Devices Service is a high-volume, safety-critical service responsible for the ongoing management of patients with implanted cardiac devices, from implant through to life-long follow-up. It provides secondary services for Cardiff and Vale patients and tertiary services for South-East Wales. An estimated 10,000 patients are routinely followed.

Approximately 800 new device implants are performed each year. Demands on the service are increasing, and the complexity of devices and device monitoring and follow-up is also increasing.

The service forms part of the wider Cardiac Physiology Department, which comprises services such as ambulatory diagnostics, cardiac devices, echocardiography, and electrophysiology support to acute cardiac services.

Since August 2023, the Specialist Services Clinical Board has been made aware of multiple concerns within the Device Service through a number of different channels such as Datix reporting, Cardiology Review, and feedback from Cardiac Physiology and wider clinical team.

- On 23rd August 2023, concerns were raised that x8 "out of date" devices had been implanted in patients between July 2024 and October 2024. This was reported to Welsh Government as an NRI (ID 73028) in October 2024. All patients were seen in clinic, informed under Duty of Candour and assured they were at minimal, if any, risk of harm. This conversation was reiterated in a letter given to them that also reinforced previous discharge advice and guidance. Immediate actions included all out-of-date devices being removed from store. A robust Stock Management Standard Operating Procedure (SOP) has also subsequently been devised and continued to be adapted in response to evolving requirements. A final draft (see Appendix 1) is pending approval with ongoing aligned work to embed in practice.

- A cluster of x5 incidents with similar themes were reported between March and April 2025 of patients on the "routine" waiting list for elective pacemaker box change who presented to the Emergency Unit or to Device Clinic having reached end of elective replacement indicator (ERI), when the battery has or is nearing depletion. The root cause was found to be appointment scheduling by administration rather than clinical staff, not appropriate for the ERI capacity.

  Key action in response to this was establishing a weekly operational meeting and validation work of all patients with the potential to have had appointment dates outside of acceptable lead time parameters and at risk of falling into this category.

  Through the meetings and validation work, further concerns became apparent:

- Demand / capacity constraints and failures in systems and processes to include an effective patient management system.

- Whilst the validation work was ongoing a patient presented to hospital as an unrelated emergency admission. A routine device check prior to theatre indicated that she also fell into the high-risk category of ERI patients but had not been picked up as part of the validation work. It was not initially clear why, but on further investigation it became evident that a significant number of patients who did not attend (DNA'd) their appointments had been automatically removed from the follow up list by the PMS system. Given the status of some of the patients within the device service, particularly those who might be pacing dependent, this was raised as a further serious clinical risk.

- Home monitoring had been considered a partial safety net since standard in 2023. Through the operational meetings concerns were raised by the Cardiac Physiology team in May 2025 however that there was a backlog in reviewing Home Monitoring. The backlog related to transmissions and delays in reviewing and acting on red flags raised via the Home Monitoring system, also resulting in clinical risk. This was subsequently reinforced by several Datix to include an incident where a home monitoring backlog was a contributary factor to a poor patient outcome (Datix ID

102844). This is currently being investigated as an NRI. An urgent recovery plan to address and eliminate this backlog was initiated and is progressing. There remains a backlog of approximately 1360 routine patients dating back to September 1st 2025.

- As part of the above work to address the Home Monitoring concern it became apparent that there was a disconnection issue from the remote monitoring platform in a with a cohort of over 600 patients being home monitored. This also needed to be addressed and has been actioned and is nearing completion.

- In January 2026 a further incident highlighted that not all devices implanted in patients were programmed correctly and activated to alert. The standard is that all home monitoring patients should have alerts set. This affected over 800 patients. The majority of these patients have been worked through, with a small number (22) still requiring a clinic appointment.

- In February 2026, a coroner's inquest was held into the death of a patient who died in April 2024 from the effects of untreated endocarditis, likely caused by a longstanding soft tissue infection at the site of a pacemaker implanted in May 2023. Despite the patient attending the Cardiac Physiology department on a number of occasions prior to his death, and indication of deteriorating cardiac function impacting on remaining battery life, the patient was not escalated to a consultant for review, which would probably have led to earlier diagnosis of the endocarditis. A Regulation 28 Prevention of Future Deaths notice was issued by the coroner in relation to concerns within the service including:
  1. Lack of guidance on when pacemaker data should trigger cardiology review
  2. Limited physiologist knowledge of infective endocarditis
  3. Inconsistent gathering of clinical information and implant site checks during clinic visits
  4. How clinical findings were documented and communicated

  This has been addressed as a separate issue but with some overlap actions to include training and education for physiologists, strengthened documentation and pathways, an escalation SOP for the unwell patent and quality audits.

CURRENT SITUATION

Expired Devices
The Patient Safety Learning Review (PSLR) was completed and NRI closed with a robust improvement plan in place to include the aforementioned SOP for stock management (Appendix 1) with a clear process from regular review of stock/stock rotation, stock selection in the storeroom to final checks during the implant procedure.

ERIs
Weekly operational meetings and validation work of all patients with the potential to have had appointment dates outside of acceptable lead time parameters were initiated with immediate effect.

An SOP for Device Clinic appointment scheduling was devised (see Appendix 2). This is based on the *British Heart Rhythm Society* guidelines and emphasizes that the responsibility is on clinical and not administrative personnel to schedule appointments.

There was also a change in the process to list for device change whilst patients still had an anticipated battery longevity of 12 months.

DNAs
Several years ago, an automatic removal algorithm was developed in collaboration with all directorates in the UHB to help appropriately manage patients within the follow up cycle

who repeatedly DNA'd their appointments in line with Welsh Government RTT guidance. It was identified that several clinics within the device service fell into this process. However, these clinics should not have been included in the algorithm due to the nature of the patients' health needs. As soon as this was identified, these unsafe auto removal practices were ceased and any patients who DNA appointments are now written to (with a copy to their GP). No patient is removed from the follow up system unless they have been reviewed by a consultant and it is safe to do so.

In order to reduce the risk of a patient DNA, text reminders are now embedded in the service and this has resulted in a measurable reduction in DNA's. All the patients who were automatically removed from follow up are being systematically validated. To date approximately 4,500 patients have already been validated to include the highest risk priority patients (Phase 1 validation). The remaining cohorts are currently undergoing administrative and clinical review, this includes 480 patients who DNA'd their appointments in 2024, and 576 in 2025 (Phase 2 validation). To date, 373 Phase 2 patients have been identified through administrative screening that require a clinical review. Once this is complete, Phase 3 will consist of the validation of 1200 patients with devices that have passed away over the last 10 years. Whilst it is recognised that patients with implanted devices and associated co-morbidities have a significant mortality rate, there is still a need to validate this patient cohort.

Patient Listing and Waiting Times:
Demand and capacity modelling for the device implant service (new implants and box changes) has been completed, with agreed standardisation of booking rules for each consultant. The backlog of patients waiting for box changes has been addressed through additional capacity implemented with the temporary support of a Clinical Research Fellow already employed within the service.

Systems and processes for adding patients to the waiting list for new implants and box changes have also been reviewed. The process is being strengthened by the implementation of an electronic waiting list card to improve transparency, consistency, and real time- oversight of patients waiting for a device. This is being rolled out week commencing 22nd June 2026.

Post Implant Follow-Up:
It was necessary to review all device patient's scheduling to ensure they had appropriately timed appointments. Priority was given to the highest risk patients according to whether they were device dependent and time elapsed since initial implant.

Throughout the review of the incidents which have occurred in the service, a key theme has been the risk associated with the use of paper records and spreadsheets to track patients. The lack of a structured digital system is open to error and a key safety risk. This is being addressed through the rollout of the Fysicon digital system. Once embedded, this will provide end-to-end visibility from new implant, to follow up monitoring, to elective replacement indictor and box change. The system went partially live on the 8th June 2026 and is currently functional in the implant service. Some VPN issues have been experienced that require a software update. Once this has been rectified it will also be rolled out for use in the management of follow up.

Remote Home Monitoring:
The capability to undertake remote monitoring of devices has been in place within physiology for 25 years. More recently, in 2023 the service was funded to provide remote monitoring to patients with high voltage systems (ICD and CRT-D). There has also been a change in BHRS guidelines promoting remote monitoring for all patients including remote only follow up for certain devices. This has resulted in:

- A significant increase in patient volume,

- Increased transmission burden,
- A higher number of alerts (both those that require action to be taken and those which do not), which has increased the need for triage, prioritisation, and filtering to identify clinically significant events,
- An increase in findings from remote monitoring which require clinical decision-making, including medication changes, urgent reviews, or escalation to other services,
- Increases in administrative workload, and
- Data management and governance.

The cumulative effect has placed strain on staffing levels, requiring reconsideration of workforce models, skill mix, and clinic structures.

To address the home monitoring concerns an urgent review of all outstanding downloads was initiated, with a sign off and escalation process implemented. Daily review was also implemented with a longer-term goal of a physiologist being fully dedicated to this work stream. A remote monitoring backlog of 1360 patients dating back to September 1st 2025 remains to be worked through.

Patients subject to disconnection and alert configuration gaps have been systematically identified as part of a separate dedicated work stream. Letters were sent to all patients who had become disconnected from the remote monitoring platform with patient and manufacturer company engagement and support to manage effectively. This is in hand and nearing completion.

In terms of alerts, there are 22 patients out of the cohort of 800 with devices implanted and functioning correctly but that are not set to activate to alert who still require face to face appointments. Refresher training for the Physiology Team has also supported addressing this concern.

The device service has mapped through the resource requirement to address the outstanding validation and capacity required for any face-to-face appointments needed. Delivery options are being costed and considered.

Stock Control:
The device service holds a significant volume of high-cost stock. From the initial incident in August 2024, it was identified that there was no standard operating process (SOP) in place for the management of stock to prevent devices from going out of date and a lack of adequate checking processes of expiry dates of devices prior to implantation. As already noted, an SOP has now been developed and issued to all staff with a clear expectation of compliance with the SOP.

In addition, Scan4Safety (a digital stock control system) has been adopted within the service, with the aim of improving traceability of devices and reducing error risk. The remaining technical issues were resolved ahead of phase II go-live on 3rd June, which will enable full linkage and traceability of devices to patients. All new stock is now scanned and assigned to patient with WiFi constraints being overridden manually at the moment.

Administrative Support:
The administrative functions are a combination of paper and computer based. The referrals for most services are received on paper; the electronic referrals are received digitally but subsequently need to be printed for access in clinic. As noted above, existing patients within the device service are managed via spreadsheets that are updated by the Clinical Lead or physiologist in clinic to guide booking appointments.

Work is ongoing to move to an electronic system (Fysicon) and interim actions have been implemented to stabilise the wating times for device implantation. Systems and processes

for the administrative teams have also been reviewed with the aim of improving consistency and streamlining administrative work.

Summary
Overall, in the last 12 months, the service has moved from reactive risk management to a more structured, proactive operating model. The focus over the coming 6 months is on embedding digital solutions, completing validation work, leadership, strengthening the clinical and administrative workforce and ensuring the improvements are embedded and sustainable.

Next Steps

- Completion of Scan4Safety Phase II
- Complete validation of the Phase 2 and Phase 3 home monitoring backlog
- Continued rollout of Fysicon and digital optimisation
- Development of KPI dashboard and enhanced governance reporting
- Full review of leadership, workforce model, and service configuration
- Implementation of digital referral systems and removal of paper processes
- Targeted recruitment and workforce development

Appendices:

- **Appendix 1 – Standard Operating Procedure for the Management of Device Stock**
- **Appendix 2 – Standard Operating Procedure for Device Clinic Follow Up Scheduling**

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
Captured on the Clinical Board and Corporate Risk Register available on AMaT, risk scoring 25.
Safety: Yes
Detailed in the main body of the report.
Financial: Yes
Options to clear the backlogs referenced in the report are currently being worked through and will have a financial implication (to be determined).
Workforce: Yes
As above re financial assessment. Long term workforce planning for sustainability is underway.
Legal: No
Reputational: Yes
Potential reputational risk for the organisation if the actions referenced in the report are not embedded in clinical practice.
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Report Title: *(needs to match agenda)*	Ophthalmology Review Update		Agenda Item No:		7.2
Meeting:	Quality Committee	Public	x	Date	30.06.26
		Private			
Lead Executive Title:	Cath Wood				
Report Author/s Title:	Rhys Andrews / General 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).*

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)*

Ophthalmology services –

- Improving position within Age-Related Macula Degeneration service, backlog reduced and cleared with a business case submitted to Values Based Realisation Group to support a sustainable delivery model for the service.
- New patients seen in 14 days (RCOphth best practice), Anti-VEGF loading <90% compliance of first 3 monthly loading doses, Lost To Follow Up cohorts – harm process in place around cohort and Follow Up Not Booked fall in cohort not booked.
- Glaucoma services – R1 high risk rated patient cohort – previous backlog of 2600 <2 years patients not seen – now eradicated and Glaucoma Diagnostic unit now live, WGOS4(Welsh General Ophthalmic Services) filtering and monitoring in place.
- High Volume Any Complexity cataract lists running from University Hospital Llandough – Clinical Implementation Network/Getting It Right First-Time recommendation and ministerial enabling action, in place and work being undertaken to support longer term plans for Cataract expansion to meet demand with CEF colleagues.
- Openeyes Electronic Patient Record implementation – All pathways in Ophthalmology now live and being used across department.
- Operai Electronic referral system is now live in CAVUHB as of June 2026, meaning all referrals being received digitally, reducing risk of lost referrals.
- Succession planning underway – New paediatric consultant recruited for planned retirement; two new consultant posts being recruited to support Oculoplastics and Glaucoma services, plans around Medical Retina and Vitreoretinal underway.
- Overall significant reduction in waiting lists in Ophthalmology, New outpatient waiting numbers without a date booked to come in is around 30% of the size against twelve months prior, with 2-year breach patients reduced by 90%.

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

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

Assurance	x	**Approval**		**Information/Noting**	

Recommendations

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

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*	

1. AMD (Medical Retina) Service – Safety and Sustainability

Current Position

The AMD service has moved from a position of high risk to increasing assurance and control, supported by:

- New patients seen within 14 days, aligning to RCOphth best practice
- Backlog cleared and pathway stabilised
- >90% compliance target for Anti-VEGF loading doses, with ongoing improvement work

Follow-up Safety (LTFU / FUNB)

- Robust harm review process now in place for Lost To Follow Up cohorts
- Regular validation processes identifying and correcting gaps in follow-up pathways
- Rapid reduction in Follow-Up Not Booked (FUNB) cohort
- Appointment tracking strengthened through planned failsafe officer model

Sustainability

- A formal business case has been developed and submitted to Values Based Realisation Group
- Focus on aligning capacity, diagnostics, and treatment demand to deliver a sustainable long-term Age-Related Macula Degeneration model

✅ **Assurance:**

There is high confidence that patients are now being safely treated and tracked, with governance processes embedded and a clear route to sustainability.

2. Glaucoma Services – Backlog Elimination and Pathway Transformation

Backlog Position

- Historical R1 high-risk cohort (>2600 patients waiting <2 years) has now been fully eradicated

Service Transformation

- Glaucoma Diagnostic Unit now operational
- Welsh General Ophthalmic Services (WGOS)4 filtering and monitoring pathways established, supporting:
    - Safe deflection of demand into primary care
    - Improved referral quality and prioritisation
    - 56% of cases managed outside hospital settings

✅ **Assurance:**

The glaucoma service has transitioned to a sustainable, risk-stratified model, with elimination of long waits and strengthened system integration.

3. Cataract Services – Capacity and Regional Delivery

- High Volume Any Complexity-enabled cataract theatres at University Hospital Llandough fully operational, aligned to:
    - Clinical Implementation Network/Getting It Right First Time recommendations
    - Ministerial enabling action

- High-volume lists (7–8 cases per session) now standard
- Continued collaboration with Capital Estates & Facilities colleagues and regional partners to:
    - Expand capacity
    - Develop a long-term cataract hub model
    - Meet growing demand

✅ **Assurance:**

Cataract services are delivering high productivity and regional support, with clear strategic expansion plans underway.

4. Digital Transformation – Quality and Safety Improvements

OpenEyes Electronic Patient Record

- Fully implemented across all ophthalmology pathways
- Significant increase in:
    - Clinical users
    - Recorded activity and documentation
- Provides:
    - Single patient record
    - Improved follow-up tracking
    - Stronger governance and audit capability

Operai Electronic Referral System

- Go-live: June 2026
- All referrals now received digitally, delivering:
    - Reduced risk of lost or delayed referrals
    - Improved referral tracking and transparency

✅ **Assurance:**

Digital systems are fully embedded, significantly improving patient safety, tracking, and service oversight.

5. Workforce and Succession Planning

- Paediatric consultant recruited to support planned retirement
- Recruitment underway for:
    - Glaucoma consultant
    - Oculoplastics consultant
- Workforce plans in development for:
    - Medical Retina (MR)
    - Vitreoretinal (VR) services
- Strengthened:
    - Job planning
    - Clinical leadership
    - Workforce sustainability pipeline

✅ **Assurance:**

A proactive succession plan is in place to maintain service resilience across key subspecialties.

6. Waiting List and Access Improvement

- Significant reduction in outpatient backlog
- New outpatient waiting list (no TCI):
    - Reduced to ~30% of previous year levels
- 2-year breaches reduced by ~90%

☑ **Assurance:**

There has been a marked improvement in access, with sustained reductions in long waits and backlog risk.

Key Risks and Next Steps

- Embedding Age-Related Macula Degeneration sustainable model following Values Based RG decision
- Continued improvement in:
    - Anti-VEGF compliance consistency
    - Follow Up Not Booked elimination and failsafe tracking
- Expansion of:
    - Cataract capacity
    - Community pathways Welsh General Ophthalmic Services (WGOS4/5)
- Ongoing digital optimisation and national integration

Conclusion

Ophthalmology services within CAVUHB have undergone significant transformation, moving from a position of clinical risk and backlog pressure to one of increasing stability, safety, and sustainability.

The Health Board can be assured that:

- Patient safety risks (particularly AMD) have been mitigated
- Backlogs have been substantially reduced
- Robust governance and tracking systems are embedded
- Clear plans are in place to sustain and build on improvements

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

Eye Care collaborative update 21st May 2026
ECCG Update Secondary care.pptx

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

Risk:

Updates or changes in risks associated with Ophthalmology			
Wet AMD patients receiving IVT treatment in appropriate timeframes			
There are currently insufficient medical and nurse resources to undertake these injections which has an impact on patient safety and quality. If these patients do not receive their treatment in the correct time frame the condition of their sight could potentially deteriorate	Workforce review, procedural development and implementation, digital record plans to be recorded for every patient, bookings to be made based on plan, separating AMD, DMO, RVO, VR injection clinics and rightsizing service on demand. Q&S nurse appointments to manage harm and risk in this cohort. Failsafe role to be filled. Appointments to clear backlog. Sustainable solution.	**Previous RR score 20**	**Current RR score 8**
Leaks affecting treatment areas			
Water leaks in suite 8 & 7 treatment rooms, laser room and OP waiting areas, stock room, office	Movement of IVT services to HCID. Clinic capacity to be reviewed elsewhere. Plans for CF unit use in UHL glauc and MR. Cavoc theatre to come online. Long term cat unit project stood up.	**Previous RR Score 16**	**Current RR Score 6**
UHL Move – Cataract theatre			
UHL move risks, split workforce resource gaps employment and finance position, no current theatre space to deliver regional cataracts	plan timetables and clinician meeting to work through plans and ensure agreement and support with plans.	**Previous RR Score 12**	**Current RR Score Removed 0**
Safety:			
Harm data from AMD and Glaucoma			
ID:Info			
AMD Harm Review	A comprehensive review of patients within the AMD service has been undertaken to identify those at risk of loss to follow-up (LTFU) or delays in care, and to assess whether any associated harm has occurred. **Cohort Overview** Approximately 300 patients were identified within the harm review cohort. Patients were flagged due to: Delayed follow-up Missed or cancelled appointments Gaps in treatment pathways Progress of Review Completed harm reviews: ~45 patients (10–15%) Ongoing reviews: ~255 patients (85–90%) Most of the cohort remains under active clinical validation, with outcome recording and harm assessment ongoing. **Harm Outcomes (Completed Reviews)**		

	Among the approximately 45 patients reviewed to date: No harm identified: 27–34 patients (60–75%) Low / mild harm: 9–18 patients (20–40%) Moderate or severe harm: 0 patients identified Where harm has been identified, it is: Low-level in nature Associated with minimal or marginal changes in visual acuity Often influenced by: Co-morbidities Patient choice Non-attendance **Refined Position (Incorporating Detailed Case Review)** Further detailed review and validation (including Datix and clinician-led assessment) indicates: Confirmed no harm: majority of reviewed cases (~65–75%) Ongoing assessment ("wait and see"): ~20–30% Confirmed harm: small minority (~5–10% of reviewed cases) **It should be noted that:** Several cases initially categorised as harm have subsequently been reclassified as no harm following consultant review. Patients in the "wait and see" group are undergoing monitoring to determine whether any visual changes are reversible and should not be considered confirmed harm at this stage. **High-Risk (Datix) Cohort** Within the subset of patients subject to Datix review: No harm: ~39% Low / mild harm: ~50% Uncertain / mixed outcome: ~11% This cohort represents higher-risk or escalated cases and therefore shows a comparatively higher proportion of low-level harm. However, no moderate or severe harm has been identified within this group. **Overall Risk Interpretation** Most patients reviewed have not experienced harm despite delays or pathway inconsistencies. Where harm has occurred, it is: Limited in scale Predominantly low-level Often clinically marginal There is currently: No evidence of moderate or severe harm No indication of widespread or systemic clinical failure **Key Risks Identified** The primary risks identified relate to operational processes, including: Delayed follow-up after treatment Unbooked follow-up appointments Incomplete review of OCT imaging Reliance on manual processes and free-text documentation

	These factors impact: Data quality Timeliness of care tracking Ability to provide real-time assurance **Conclusion** Findings to date are reassuring. Most patients reviewed have experienced no harm, and where harm has been identified, it is low-level and clinically limited. However, a significant proportion of the cohort remains under review. The principal risk at this stage is operational, relating to completion of validation and follow-up processes, rather than clinical safety.
Glaucoma Harm Review	A total of 102 patients have been identified for harm review following the glaucoma validation exercise. To date, 29 patients (28%) have completed harm review with a confirmed outcome. Of these, the majority (25 patients) had no harm or no clinical issue identified, with findings largely related to pathway complexity, administrative gaps, or patients not requiring ongoing follow-up. A small number of cases (4 patients) have identified clinical harm, which have been escalated and are being managed appropriately. The remaining 73 patients (72%) are currently progressing through the harm review process, with appointments arranged or clinical review ongoing.

ALERT, ADVISE, ASSURE (AAAs) HIGHLIGHT REPORT	
Committee/Group	**Safeguarding**
Meeting Date	02/06/2026
Lead	Executive Nurse Director
Report by	Deputy Executive Nurse Director

This summary highlights matters arising from the Safeguarding Steering Group held on 2 June 2026 to Quality Committee under the headings of Alert, Awareness and Assurance.

The Safeguarding Steering group minutes of meeting held on 11 March 2026 have been approved and are for noting to Quality Committee.

ALERT

(Alert the Committee to areas of non-compliance or matters that need addressing urgently)

Mental Capacity Act (MCA) Compliance: A case review presented through the mortality review process identified significant deficiencies in capacity assessments, best-interest decision-making, consent processes, use of restraint, covert medication practices, and advocacy involvement. Members acknowledged that these issues are not historical anomalies and may reflect wider organisational practice. Clinical Boards have been asked to develop improvement actions and an overarching Health Board improvement plan is being considered. This will be completed and presented at the next SSG

Safeguarding Level 3 Training Compliance: Compliance remains below expected levels across several Clinical Boards despite improvements in training provision. This remains an organisational risk requiring continued oversight. Low Level 3 safeguarding training compliance reflects a historic mismatch between the mandatory training requirement, which increased from around 1,000 to nearly 7,000 staff over three years, and the training offer available; this risk sits with Clinical Boards but is being mitigated through a revised training plan targeting at least 2,400 staff annually, additional dates, professional advice line support, strengthened Safeguarding Steering Group oversight, and a wider service review to support statutory assurance

Attendance and Representation: The Group noted poor attendance from some areas, including Mental Health representation, with actions agreed to improve attendance and accountability

ADVISE

(Detail here any areas of on-going monitoring where an update has been provided to the subcommittee AND any new developments that will need to be communicated or included in operational delivery)

The Group considered implications arising from the **Baroness Casey Review**, **Bravery Through Justice Review**, and emerging learning from the **Fuller Inquiry**, recognising the need to strengthen professional curiosity, information sharing, exploitation awareness, safeguarding of vulnerable children and protection of deceased patients. Task and finish groups are being established to oversee implementation of relevant recommendations. Draft Terms of Reference have been developed for the proposed groups, setting out their scope, expected timelines and

reporting responsibilities to the Safeguarding Steering Group; these will be shared with the Group for assurance once membership is confirmed and the Terms of Reference are agreed

A new Health Board-wide safeguarding dashboard has been developed to improve visibility of safeguarding activity, referral trends and practitioner concerns and will support future thematic reporting and organisational intelligence.

Updates were received on forthcoming Welsh safeguarding procedures, Section 5 arrangements and Prevent training developments

ASSURE

(Detail here any areas of assurance that the committee has received)

Clinical Boards continue to monitor safeguarding referrals, professional concerns, training compliance, pressure damage, and safeguarding performance through established governance arrangements.

The Safeguarding Team has expanded Level 3 safeguarding training provision through a revised virtual model, with strong attendance reported and additional sessions planned to improve compliance.

Assurance was provided that reviews arising from the Public Health Wales Sexual Health Wales Test and Post incident identified no significant safeguarding risks requiring further action within Cardiff and Vale UHB, with all relevant cases reviewed appropriately.

The Group agreed to strengthen organisational oversight through enhanced reporting, thematic learning, dashboard development and delivery of improvement plans arising from MCA audits and national safeguarding reviews.

ALERT, ADVISE, ASSURE (AAAs) HIGHLIGHT REPORT	
Committee/Group	**Infection Prevention and Control Group**
Meeting Date	16/06/2026
Lead	Executive Nurse Director
Report by	Deputy Executive Nurse Director

This summary highlights matters arising from the Infection Prevention and Control Group held on 16 June 2026 to Quality Committee under the headings of Alert, Awareness and Assurance.

In summary IPCG received assurance that overall infection prevention and control arrangements remain effective, with positive performance against several national HCAI indicators. However, focused executive oversight is required in relation to MRSA performance, the West 8 outbreak, isolation capacity constraints and variable Clinical Board engagement with IPC governance arrangements.

ALERT

(Alert the Committee to areas of non-compliance or matters that need addressing urgently)

An ongoing **MRSA outbreak on West 8 (Spinal Rehabilitation)** was reported, with 11 MRSA-positive patients identified since January 2025. Audit findings identified poor compliance with infection prevention standards, including bare below the elbow requirements and gaps in local audit activity. A robust outbreak action plan, enhanced screening and intensified auditing arrangements are now in place.

MRSA remains the Health Board's most significant healthcare-associated infection concern, with 18 cases reported in 2025/26 and four cases already identified in the current year. Executive oversight meetings with Clinical Boards have been established to strengthen accountability and improvement actions.

Specialist Services highlighted ongoing challenges associated with **critical care isolation capacity**, resulting in occasions where patients with C. difficile and influenza could not be isolated due to competing clinical priorities.

Attendance from several Clinical Boards at IPCG was poor, with Children & Women's, Mental Health and other areas not represented. The Chair indicated this would be escalated through Director of Nursing arrangements

ADVISE

(Detail here any areas of on-going monitoring where an update has been provided to the subcommittee AND any new developments that will need to be communicated or included in operational delivery)

Significant learning has emerged from the **Paediatric Oncology C. difficile improvement programme**, which has achieved approximately a 75% reduction in cases through targeted antimicrobial stewardship, improved isolation practices, environmental cleaning and education. IPCG agreed that this learning should be disseminated more widely across Clinical Boards.

Medicine Clinical Board has introduced a new **IPC Review Panel** model to strengthen oversight of healthcare-associated infections, thematic analysis and implementation of learning from RCAs. This approach may offer wider organisational learning.

Clinical Boards reported concerns regarding variation in ANTT reporting methodologies. Further work is required to standardise measurement and reporting arrangements to ensure consistency and meaningful benchmarking across the organisation.

IPCG discussed reviewing and simplifying the existing **"Safe to Move"** patient transfer risk assessment process to support safer patient flow and reduce avoidable infection-related bed closures.

ASSURE

(Detail here any areas of assurance that the committee has received)

Overall healthcare-associated infection performance remains relatively positive. The Health Board achieved Welsh Government targets for MSSA, E. coli and Pseudomonas in 2025/26, with C. difficile rates remaining amongst the lowest in Wales despite narrowly missing the internal reduction trajectory.

Internal Audit recommendations relating to IPC governance are nearing completion, including policy review and development of an annual IPC programme aligned to the Welsh Government Quality Statement. A gap analysis has been completed and is awaiting final review before wider dissemination.

Preparations for potential **High Consequence Infectious Disease (HCID)** presentations continue to progress well. Training, pathways, governance arrangements and SharePoint resources are in place, with assurance provided that relevant clinical areas have trained staff available.

Estates and Facilities reported continued monitoring and management of Legionella and water safety risks, implementation of chlorine dioxide systems, ongoing flushing programmes and progress with decontamination infrastructure developments, including the new HPV decontamination facility.

Updated IPC policies continue to be maintained. The revised **Clostridioides difficile Procedure** was ratified by the Group and the updated Viral Gastroenteritis Procedure was issued for consultation.