CARDIFF AND VALE UNIVERSITY HEALTH BOARD

PUBLIC Quality Committee

27th October 2026 at 9am via Microsoft Teams

CHAIRS INFORMED AGENDA

09:00	1	Preliminaries	Assurance / Approval or Noting&Information	Presenters
	1.1	Welcome, Introductions & Apologies for Absence		Ceri Phillips
	1.2	Declarations of Interest		Ceri Phillips
	1.3	Minutes of the last meeting held: *29.09.2026*		Ceri Phillips
	1.4	Action Log – following meeting held on: *29.09.2026*		Ceri Phillips
09:05	**2**	**Strategy: Providing Outstanding Quality**		
0 mins	2.1	Board Assurance Framework (BAF)	Assurance	Matt Phillips
09:05	**3**	**Shaping our Quality, Value & Sustainability**		
10 mins	3.1	Discharge Advice Letters (DALs)	Noting & Information	Alex Scott
10 mins	3.2	Update on Fuller Report Recommendations	Assurance	Helen Luton
09:25	**4**	**Shaping our Population Health and Place-Based Partnerships:**		
10 mins	4.1	Looked After Children Assessment Backlogs Update	Assurance	Jason Roberts
09:35	**5**	**Shaping our Future Clinical Services**		
10 mins	5.1	Eating Disorder Service Review Update	Assurance	Sam Barrett
09:45	**6**	**Quality Performance Reporting**		
	6.1	*No items.*		
09:45	**7**	**Item for Oversight / Scrutiny**		
30 mins	7.1	Clinical Board Highlight Reports: ○ *Medicine Clinical Board* ○ *Specialist Services Clinical Board* ○ *PCIC Clinical Board* ○ *CD&T Clinical Board* ○ *Children & Women Clinical Board*	Assurance	Execs

		○ *Surgery Clinical Board* ○ *Mental Health Clinical Board*		
5 mins	7.2	Clinical Effectiveness Committee highlight report	Assurance	Alex Scott
10 mins	7.3	Summary of Recent Healthcare Inspectorate Wales (HIW) Inspection Reports	Assurance	Alex Scott
5 mins	7.4	Public Services Ombudsman for Wales Annual Letter 2025-26	Assurance	Angela Hughes
10 mins	7.5	Annual Reports: i) Duty of Candour Annual Report 2025/26: Application of the Process, Themes, Trends and Staff Survey Findings	Assurance	Angela Hughes
10:45	**8**	**Mental Health Legislation**		
10 mins	8.1	Consent	Assurance	Natasha Goswell
10 mins	8.2	Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS)	Assurance	Natasha Goswell
11:05	**9**	**Policies for Approval**		
	9.1	*No items.*		
11:05	**10**	**Items for Noting and Information**		
	10.1	*No items.*		
11:05	**11**	**Any Other Business**		
	11.1			Ceri Phillips
11:05	**12**	**Review of Meeting**		
	12.1	*Board and Committee Self-Assessment link*		Ceri Phillips
	12.2	**Time and date of the next meeting:** *Monday 30th November 2026 at 9am via MS Teams*		
	12.3	**Declaration before moving into private session:** *To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]*		

Draft Minutes of the Public Quality Committee
Held on 29th September 2026 via MS Teams

To view the meeting: https://youtu.be/xIF9YChXNtk

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Kirsty Williams	KW	UHB Chair
In Attendance		
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
David Fluck	DF	Executive Medical Director
Natasha Goswell	NG	Deputy Executive Nurse Director
Angela Hughes	AH	Assistant Director of Patient Experience
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness
Jason Roberts	JR	Executive Nurse Director
Matt Phillips	MP	Director of Corporate Governance
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Additional Attendees		
Jane Brown	JB	Interim Head of Corporate Governance
Sion Lingard	SL	Deputy Director of Public Health / Consultant in Public Health
Abraham Theron	AT	Clinical Board Director – Surgery
Lauranne Cullen	LC	
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Chris Bown	CB	Chief Executive Officer
Judi Rhys	JRH	Independent Member – Third Sector
Stephen Riley	SR	Independent Member – University
Rachna Upadhya	RU	Independent Member - General

QC 26/09/1.1	**Welcomes, Introductions & Apologies** Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh and apologies for absence were noted.	
QC 26/09/1.2	**Declarations of Interest** No declarations of interest were raised.	
QC 26/09/1.3	**Minutes of the Committee meeting held on 28.07.2026** The minutes of the Committee meeting held on 28.07.2026 were received. **The Committee resolved that:** a) The minutes of the meeting held on 28.07.2026 were approved as a true and accurate record of the meeting.	

QC 26/09/1.4	**Action Log** The Action Log following the meeting held on 28.07.2026 was received and discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 28.07.2026 was noted.	
QC 26/09/1.5	**Committee Chair's Actions** No Chair's Actions were raised.	
	Quality Performance Reporting	

QC 26/09/3.1	**Shaping our Future Quality Excellence – Acute Deterioration**
	
	Abraham Theron (AT), Clinical Board Director – Surgery Clinical Board, presented the slides to the Committee and summarised the following:
	• The Acute Deterioration Board covered four main workstreams: Early Warning Scores (EWS), Call 4 Concern, Sepsis, and Treatment escalation plans. Treatment escalation plans were being considered as a separate programme with dedicated governance arrangements.
	• Welsh Government (WG) directed the implementation of four standardised EWS tools across Wales by September 2025. The expectation was for all UHBs to implement despite no additional resource being provided.
	• NEWS 2:
	  o NEWS2 score had to be introduced to every adult inpatient in CAVUHB, with different responses required for different areas.
	  o Approximately 6,500 staff received training, supported by a Task and Finish Group established to oversee implementation. NEWS2 was introduced in July 2025 to allow additional support ahead of the annual doctor changeover.
	  o Escalation pathways were redesigned to ensure implementation remained resource neutral, with greater emphasis on primary clinical teams and support from the Patient at Risk Team (P@RT).
	• Audit data demonstrated improving compliance with the completion of observation charts and escalation processes. Correct chart usage and score calculations were now consistently achieved, with most escalations undertaken appropriately and within expected timescales.
	• Monitoring indicated that implementation had not overwhelmed deterioration or resuscitation services. Referrals and fast-bleep usage remained manageable, and there was evidence of appropriate escalation of deteriorating patients.
	• Early outcome data suggested a reduction in cardiac arrests alongside an increase in peri-arrest interventions, indicating earlier recognition and management of acutely unwell patients.
	• Feedback from resident doctors was broadly positive, with respondents reporting that current escalation arrangements were accessible, proportionate and effective.
	• A Call 4 Concern programme was being implemented following WG direction in January 2026, providing patients, families and carers with a formal mechanism to raise concerns about deterioration. The adult pathway was established, maternity had recently gone live, and implementation was progressing within mental health and community services.
	• Sepsis improvement work continued, including leadership transition arrangements, development of nursing leadership capacity, charity-funded staff training through the UK Sepsis Trust, and a successful sepsis awareness event.
	• Overall assurance was provided that all four EWS had been successfully implemented, compliance was improving, escalation processes were operating effectively, and there was currently no indication of adverse impact on patient outcomes. It was still early days for Call 4 Concern, with further updates in the future to follow. Electronic observations were expected to provide further benefits in the future.
	
	Paul Bostock (PB), the Chief Operating Officer, expressed concern that the Call 4 Concern process may not be widely understood by the public, particularly as the equivalent scheme in England, Martha's Rule, had received greater publicity.
	
	AT responded that the branding and terminology for Call 4 Concern was determined nationally and could not be changed locally, and any changes would require agreement at WG level. AT noted that	

	many calls received related to general concerns rather than acute deterioration, which highlighted the need for greater public understanding of the scheme's purpose. PB asked whether communications could better explain that it was the Welsh equivalent of Martha's Rule. Jason Roberts (JR), the Executive Nurse Director, acknowledged that WG required the scheme to be branded differently from Martha's Rule, including restrictions on referencing the English model. JR agreed that local communications should be refreshed, whilst discussions continued with WG on the potential for greater alignment and public recognition. Angela Hughes (AH), the Assistant Director of Patient Experience, noted that the name "Call 4 Concern" may be confused with the Complaints/Concerns team. AH added that using a three-option wellness score (better, same, worse) may lead respondents to default to the middle option, and consideration should be given to using four response choices to encourage more meaningful feedback. David Fluck (DF), the Executive Medical Director, asked how to move further upstream and whether there were any remaining gaps where earlier intervention could be targeted. AT responded that cases where deterioration was not recognised and poor outcomes occurred should continue to be reviewed through existing governance processes. Significant resuscitation data was available, including evidence that resuscitation calls were more likely around staff handovers, a pattern also seen nationally. Further analysis of this data may help identify factors contributing to deterioration recognition and opportunities for earlier intervention. Kirsty Williams (KW), the UHB Chair, sought clarification on whether all four tools had been fully implemented as expected and whether the organisation was compliant with national requirements. KW asked about plans to refresh awareness of Martha's Rule among patients and families, benchmarking against other Welsh organisations, and the use of comparative data from England to assess awareness levels and inform discussions on potential improvements to the Welsh approach. AT confirmed that all four EWS tools were implemented on time and fully embedded, with data reporting through the All-Wales implementation network. However, the Call 4 Concern element was less mature, and further benchmarking against comparable organisations in Wales and England would be needed to assess activity levels and identify opportunities for improvement as more comparable data became available. JR acknowledged that work was underway with the Chief Nursing Officer (CNO) to compare performance with England and understand variations in implementation. A refreshed communications strategy was being developed, including renewed publicity, updated materials and digital approaches, to increase awareness of Call 4 Concern. AT added that options being explored included bedside stickers displaying Call 4 Concern contact details and patient information leaflets highlighting how and when to raise concerns. These measures formed part of a wider communications strategy. KW suggested consideration be given to including key information on patient wristbands. AH suggested information also be promoted through volunteer activity trolleys, QR codes, contact details and volunteer uniforms. Aled Roberts (AR), the Associate Medical Director Patient Safety and Clinical Effectiveness, noted that several initiatives were underway to support earlier care planning and prevent deterioration. AR agreed there was a need to bring these strands together to support appropriate escalation decisions and strengthen the preventative approach. **Bring an update on Acute Deterioration / Early Warning Scores and Call 4 Concern back to Quality Committee in spring 2027 - ACTION** **The Committee resolved that**: a) The Acute Deterioration update was noted.	

QC 26/09/2.1	**Integrated Performance Report (IPR)** AS presented the IPR, and highlighted the following to the Committee: • This was the second iteration of the IPR which highlighted a mixed quality and safety position. • During August 2026, 15 Nationally Reportable Incidents (NRIs) were reported in the month prior. The long-term themes around NRIs continued to show themes around perinatal mortality and pressure damage. Every perinatal mortality case is subject to a multi-professional review that fed into the wider MBRRACE work. The UHB was underway with a Pressure Damage Collaborative to strengthen the governance, oversight, training, awareness and targeted areas of improvement. • Patient experience feedback continued to identify communication, waiting times and care coordination as key areas of concern raised, whilst infection prevention and control (IP&C) performance remained mixed with ongoing challenges related to Klebsiella, C.diff and MRSA. • Positive improvements were noted in the timeliness of incident investigations, with significant reductions in the number of NRIs that remained under review and overdue cases, and patient safety incidents that remained under investigation for a prolonged time, alongside good compliance with the WHO Surgical Safety Checklist and continued quality improvement activity across the organisation. KW sought assurance that Nationally Reportable Incidents (NRIs) were within expected ranges, and that robust organisational learning was being captured and implemented from investigations. AS responded that the UHB had a high reporting rate for NRIs which reflected a strong reporting culture and appropriate review thresholds. Previous reviews of NRIs closed for more than 12 months identified that the recorded level of harm was subsequently downgraded in over 70% of cases. Learning from incidents informed organisation-wide improvement programmes, with examples including work on deteriorating patients, IP&C, continuity of care, and digital solutions to reduce patient identification errors. KW asked how the organisation distinguished between high incident reporting rates driven by a strong reporting culture, and rates that may indicate underlying safety concerns, and whether the downgrading of harm following review was a key measure of this balance. AS responded that the UHB received approximately 24,000 incidents a year through the Datix system, and there were processes in place to ensure there was corporate oversight and discussion at Clinical Board levels and with Executive colleagues to ensure this was proportionate. Whilst NRI reporting rates were higher than many organisations, reviews often identified lower levels of harm than initially anticipated, and findings were used to drive both local and organisation-wide improvement initiatives, with a continued focus on proportionate investigation and learning. JR provided assurance that the UHB's high reporting rates reflected a strong culture of openness and learning. While further work was needed to strengthen how learning and downgraded harm data were reported, ongoing quality and clinical safety governance developments, including the Quality Management System (QMS), were intended to enhance the cycle of reporting, investigation, learning and improvement. AH explained that learning from incidents, claims, redress cases and near misses were essential to preventing recurrence and harm. AS added that CAVUHB's NRI rate was 2.89 per 100,000 population, compared with the Wales average of 2.43. Comparisons were affected by reporting methodology and did not fully account for the UHB's tertiary population.	

	The Committee resolved that: A) The data and narrative included in the performance report were noted.	
	Items for Oversight / Scrutiny	
QC 26/09/3.2	**Clinical Board Highlight Reports** JR presented the reports to the Committee and highlighted the following: • This was the third iteration of the Clinical Board AAA reports and noted the increased maturity in governance oversight and risk visibility across the organisation. • Recurring themes included workforce fragility, particularly within Mental Health, Maternity and PCIC services, with staffing pressures increasingly impacting patient access, flow and safety. Assurance is dependent on the ongoing recruitment and sustainable service models. • Delays in access to care and waiting list harms remained significant concerns, reflecting ongoing demand and capacity challenges across a number of specialties. • Ongoing work to improve the quality, accuracy and timeliness of discharge communications between secondary and primary care was highlighted, including the use of discharge advice letters and digital systems to strengthen compliance. • The continued impact of the ageing estate infrastructure on patient access, diagnostics and operational performance was noted, with assurance limited pending longer-term funding and sustainable solutions. • Positive progress was reported in a number of areas including WHO Surgical Safety Checklist compliance, the Eating Disorders Transformation Programme, and strengthening Clinical Board governance arrangements. • Significant improvements in incident management were noted, including substantial reductions in Datix backlogs, NRIs under review, and overdue investigations. CP asked Natasha Goswell (NG), the Deputy Executive Nurse Director, for her assessment of where they are with these Clinical Board AAA Highlight reports. NG responded that clinical governance arrangements within the Clinical Boards continued to strengthen, with the AAA reports providing improved visibility of risks and performance. Whilst further development was required, the reports were seen as evidencing a positive trajectory, supported by the ongoing implementation of the QMS. PB suggested that further executive moderation prior to Quality Committee consideration would help ensure risks and issues were presented consistently and proportionately. CP noted variability in how Clinical Boards utilised the AAA reporting framework and agreed that further refinement was required. CP invited comments on the Welsh Gender Service in light of recent scrutiny. DF noted that surgical referrals and intervention within the Welsh Gender Service had been paused by the Joint Commissioning Committee (JCC) in August 2026 following concerns that referral rates for surgical intervention were higher than those seen in England. An independent review of referral processes was being established, whilst the service continued to provide support and regular communication with affected patients and staff, with the aim of resuming referrals as soon as possible. KW welcomed the greater visibility of risks and challenges within the AAA reports. Whilst reporting maturity was improving, concerns were raised regarding variation in reporting approaches, the need for greater standardisation and moderation, and ensuring that identified risks resulted in clear organisational action, accountability and improvement. KW asked what the Quality Committee did with these reports as a result.	

	CP asked for further information around the issues in the prison service. PB suggested discussing the prison service in the private Quality Committee session. PB agreed that the AAA reports should be used to identify areas that require deeper scrutiny and assurance by the Committee and inform future agenda items and discussions. JR emphasised the importance of balancing transparency and openness about risks with providing assurance on actions and improvements. Further work was required to strengthen moderation, consistency and communication of the actions being taken in response to identified risks. **The Committee resolved that:** A) The Clinical Board Highlight Reports were noted for assurance.	
QC 26/09/3.3	**Clinical Safety Group (CSG) Highlight Report** AS presented the report and summarised the following: • The CSG reviewed key quality and safety risks across the UHB in August 2026, including outsourced endoscopy follow up processes, service capacity pressures in diabetes, dermatology and ADHD services, district nursing workforce challenges, and risks associated with digital implementation. • Common themes identified from incidents, inspections and mortality reviews included communication, documentation, escalation of deterioration and compliance with policies and training requirements. • Positive progress was noted in IP&C, theatre audit assurance, mortality governance and oversight, and the establishment of the Pressure Damage Collaborative to address pressure damage rates. • The CSG reviewed its scope and arrangements to strengthen oversight of risk and assurance across the clinical effectiveness framework. AR noted plans to strengthen the role of the CSG, including improving engagement with Clinical Boards, enhancing the escalation of risks and assurance, and refining how quality and safety information is reported to the Quality Committee. **The Committee resolved that:** A) The information provided to the CSG and the ongoing actions as well as the development of the agenda to support improved engagement and representation was noted.	
QC 26/09/3.4	**Clinical Effectiveness Committee (CEC) Highlight Report** AS introduced the report and provided the following summary to the Committee: • The CEC in September 2026 received assurance regarding performance and improvement activities across the National Respiratory Audit Programme, paediatric asthma, and the delivery of the Welsh Respiratory Quality Statement. • Significant improvements were noted in audit participation, data quality and compliance with national standards, alongside strong performance in areas such as tobacco dependency interventions, oxygen prescribing, and invasive ventilation. • Ongoing challenges remained in relation to prolonged waiting times for pulmonary rehabilitation, respiratory diagnostics and interstitial lung disease waiting times, although service redesign, workforce investment and pathway improvements were beginning to demonstrate benefits, including early reductions in respiratory-related emergency attendances and admissions. AR welcomed the joined-up approach taken by the Respiratory Service, which combined national audit findings with quality, waiting list and service improvement work to support	

	quality planning and service development. While challenges remained, particularly in pulmonary rehabilitation, assurance was provided that services are using audit findings constructively to drive improvement and prevention-focused care. DF noted that the Clinical Board were reviewing their services across respiratory and looking to move resources to fill this gap in pulmonary rehabilitation. CP highlighted the opportunity to align pathway changes with the Clinical Services Plan (CSP) and sought assurance on the extent to which this was had been progressed. AR noted the importance of pulmonary rehabilitation and community-based support in preventing admissions and supporting a shift towards preventative care. Assurance was provided that these priorities were recognised by the Clinical Board and were being progressed through service improvement and escalation processes. Emma Cooke (EC), the Executive Director of AHPs, Health Scientists and Community Services Development, highlighted the importance of strengthening preventative and community-based respiratory care, with a focus on improving support for people with existing long-term conditions whilst also shifting further upstream to prevent ill-health and reduce future demand on services. Claire Beynon (CB), the Executive Director of Public Health, noted ongoing public health and respiratory improvement work focused on smoking prevention and cessation, including school-based education programmes, the development of smoke-free ambassadors, and closer integration between respiratory services and stop smoking support. The importance of expanding preventative interventions and reaching people earlier to reduce the burden of respiratory disease was highlighted. **The Committee resolved that:** A) The assurance provided by the clinical performance reported in the national audits and the improvement work that was underway to address requisite improvement was noted.	
QC 26/09/3.5	**Health Inspectorate Wales (HIW) Inspections Report** AS presented the report and highlighted the following: • Positive findings from recent HIW inspections across primary and secondary care were noted, including compassionate care, positive patient experiences, effective multidisciplinary working and committed staff teams. • Inspections also highlighted recurring improvement themes relating to estate and environmental issues, including maintaining dignified care environments, medication storage, records management and equipment storage to support IP&C. • Assurance was provided that improvement plans were actively monitored, with regular progress updates submitted to HIW and ongoing oversight of actions that remained outstanding. • In primary care, independent contractors were responsible for implementing required improvements, supported by follow-up assurance processes to ensure actions were embedded and sustained. CP sought assurance that learning from HIW inspections were shared across the organisation. AS responded that learning from common HIW inspection findings was applied across the organisation. For example, medication storage issues had been addressed through a UHB-wide review of clinical areas against national standards, with improvement actions monitored through Clinical Boards and the Medication Safety Executive, alongside plans for re-audit and ongoing oversight. A repeat audit was scheduled for early 2027.	

	KW highlighted concerns about the condition of the estate and facilities were consistently raised through HIW reports and Leaders That Listen visits. She asked whether this feedback was collated and shared with the Estates and Executive teams to strengthen the evidence base for business cases and support investment and improvement decisions. AS responded that whilst the Estates team worked closely with services to address issues identified, the approach was often reactive. AS agreed that there was value in collating this feedback and using it more strategically to support business cases and inform wider Executive discussions on estates investment and improvement. JR noted that the discussion highlighted the growing concern about the condition of the UHB's estate and the impact this is having on service delivery. Both Executive colleagues and frontline staff were increasingly concerned about the environments in which care was provided, with estates issues featuring prominently in the Clinical Board AAA reports. JR acknowledged that a more strategic, organisation-wide approach was needed. AH explained that volunteers provided valuable independent perspective, and often highlighted issues that staff may have become accustomed to. PB reported that CAVUHB had an estimated £800m backlog maintenance requirement, including around £50m of critical infrastructure risks such as roofs and electrical systems. Whilst these issues may not visibly improve care environments, they presented significant operational and safety risks. PB suggested that a wider Board discussion may be required to consider the scale of the challenge and the implications for service delivery and patient safety, as some risks may no longer be tolerable without further action. KW suggested that, alongside assessing critical infrastructure risks, the organisation should develop a more holistic understanding of the impact of the estate on service delivery. This should include opportunity costs associated with poor infrastructure, such as reduced capacity, inefficiencies, and impacts on clinical effectiveness, patient safety and performance. The importance of bringing these factors together to provide a comprehensive picture of the risks and consequences of underinvestment in the estate was emphasised. JR noted that the full impact of estate challenges was difficult to quantify, as clinical teams often developed workarounds to maintain services, which could mask underlying risks. While staff remained committed to delivering care, concerns were raised that organisations could become desensitised to substandard environments. PB agreed that the impact of estate challenges should be assessed more comprehensively but recognised that not all issues could be attributed to infrastructure alone and that services must continue to maintain standards and good practice. DF noted that addressing estates challenges must be closely aligned to the CSP and wider service transformation opportunities. The UHB must also consider how existing infrastructure could be used more effectively. **Arrange a further strategic discussion, potentially through a Board development session, on the critical estates risks, required investment and the organisation's tolerance of those risks – ACTION.** **The Committee resolved that:** A) The actions taken in response to recent HIW inspection findings across secondary and primary care services were received for assurance. B) The progress of associated improvement plans was noted. C) The continued organisational learning arising from inspection activity was endorsed.	

QC 26/09/3.6	**Thirlwall Inquiry: Executive Summary, Recommendations and Organisational Assurance** JR presented the report to the Committee and highlighted the following: • This was recognised as one of the most significant patient safety failures in NHS history, and there were important lessons for healthcare organisations across the UK. • The findings reflected a systemic failure to recognise, connect and escalate safety concerns, with patient protection hindered by fragmented governance arrangements, professional loyalties, employment processes and concerns regarding organisational reputation. • Patient safety depended not only on policies and governance structures, but also on an organisational culture that listened to concerns, responded to signs of harm, and acted decisively when risks were identified. • Key themes highlighted included ensuring patient safety took precedence over organisational considerations, strengthening Board assurance around whether systems were operating effectively in practice, embedding candour and family involvement as core safety interventions, and continuing to enhance mortality surveillance and learning processes. • Assurance was provided that there was no evidence of similar findings within CAVUHB. However, the organisation took the report seriously and were considering the wider implications for clinical and organisational governance. • A formal gap analysis against the 17 recommendations would be undertaken through the Pathways to Safer Beginnings Oversight Board, with a detailed report on findings, assurance and any required actions to be presented at a future Committee meeting. **Undertake a formal gap analysis against the 17 recommendations arising from the Thirlwall Inquiry and bring a detailed report back to Committee in November – ACTION.** **The Committee resolved that:** a) The	
	Strategic Portfolio: <u>Providing Outstanding Quality</u>	
QC 26/09/4.1	**Board Assurance Framework (BAF)** **The Committee resolved that:** A) The BAF was noted for assurance.	
	Shaping our Population Health and Place-Based Partnerships	
QC 26/09/5.1	**Cardiff and Vale UHB Hepatitis B&C Elimination Action Plan 2026-2028+** CB and Sion Lingard (SL), the Deputy Director of Public Health / Consultant in Public Health, introduced the report and summarised the following: • The Plan supported the WG ambition to eliminate Hepatitis B and C in Wales by 2030. • Developed in partnership with local authorities, the third sector and other stakeholders, the Plan aligned with national priorities and focused on four key areas: infection prevention, testing and case finding, treatment and engagement, and improved data intelligence. • Key actions included strengthening hepatitis B vaccination programmes and reengaging service users with misuse services and needle exchange programmes, expanding testing and opt-out testing (particularly for higher-risk groups and prison populations), improving access to treatment and peer support, and enhancing surveillance and population health intelligence to better target interventions.	

	• Significant progress had been achieved through the previous action plan, including increased testing capacity, mobile outreach initiatives and enhanced support for substance misuse services. • Delivery of the plan would be overseen through a multi-agency partnership group involving UHB services, Public Health Wales (PHW), local authorities and third-sector organisations. The plan did not currently require additional resources, although future workforce requirements may be identified through separate business planning processes. KW recognised that Hepatitis B and C services often supported some of the most marginalised and vulnerable groups within the population. **The Committee resolved that:** A) The Cardiff and Vale UHB Hepatitis B&C Elimination Action Plan 2026-2028+ was approved.	
QC 26/09/5.2	**Cardiff and Vale UHB Pandemic Response Plan** CB and SL introduced the report and highlighted the following: • The plan had been developed to complement existing major incident and business continuity arrangements, and incorporated learning from the COVID-19 pandemic national exercises and the ongoing UK COVID inquiry. • The plan was designed to be adaptable to different types of pandemics, sustainable over prolonged periods, and focused on practical actions through a series of operational action cards. • Key themes included workforce wellbeing, health inequalities, agile responses to evolving national guidance, and a whole-system approach involving health, local authority, community and third-sector partners. • The plan aligned with regional and national pandemic frameworks and was structured around the recognised phases of a pandemic response: containment, mitigation and recovery. • Extensive engagement had informed the plan, and it would continue to evolve as further learning was identified through exercises and real-world experience. PB sought assurance on how the plan had been tested and validated, noting that pandemic responses differed significantly from major incidents due to their scale and prolonged duration. PB requested clarification on the level of scrutiny and stress-testing undertaken prior to approval. SL responded that the plan had been developed in partnership with Emergency Preparedness, Resilience and Response (EPRR) colleagues and aligned with regional arrangements across South Wales. Whilst it had not yet been formally exercised locally, it reflected learning from national and regional pandemic preparedness work, including exercises undertaken by other UHBs. SL noted that the plan would be tested and refined through future exercises and would continue to evolve as further learning emerged from the COVID inquiry and national pandemic preparedness programmes. PB clarified that this was more around business continuity than a major incident.	

	CB explained that the plan had been developed with extensive input from EPRR colleagues, clinical boards and services across the organisation, ensuring that those identified within the response structure understood their roles and responsibilities. KW sought clarification that the intention was to approve the current framework, undertake exercises to assess its effectiveness in practice, and subsequently update the plan to reflect any lessons identified. CB confirmed this was correct. PB noted concern that it had reached Committee for approval before being considered by the Senior Leadership Team (SLT) or supported by a clear testing and implementation plan. PB suggested an intermediate stage of scrutiny may have been missed. CB responded that the plan had originally been intended for consideration by SLT but was brought directly to Committee following changes to governance arrangements. Assurance was provided that extensive consultation had taken place across the organisation during its development, and no significant concerns were anticipated prior to approval. CP agreed with KW's suggestion of approving the plan on the basis that the document was a working plan to be tested and revised, with further ratification and development as exercises and national learning became available. **The Committee resolved that:** A) The revised Pandemic Response Plan for Cardiff and Vale UHB was approved on the basis that the document was a working plan to be tested and revised, with further ratification and development as exercises and national learning became available.	
QC 26/09/5.3	**Public Health Wales (PHW) Sexual Health Incident Update** CB and SL presented the update and summarised the following: • This was a further update on the PHW sexual health testing and postal service incident, which had previously been reported to the Quality Committee in April 2026. • The first incident related to child and adult safeguarding issues where their online tool was not potentially identifying exploitation risks. The second related to patient safety concerns where false results were being reported. The third incident related to information governance issues where patient identifiable information had been sent to the wrong UHB, and incomplete data protection impact assessments had been completed. • Since the previous report, additional issues had been identified, including some HIV-positive service users not being appropriately routed for Hepatitis C testing and instances where test results were communicated by text message despite individuals having opted out of this method. • PHW had established an Incident Management Team, escalated oversight to Chief Executive level, and had since concluded its investigation in August 2026. An independent external review had been commissioned, with work commencing in August 2026. • Safeguarding reviews had been completed across Wales, including within CAVUHB, with appropriate referrals made where required. • PHW had also implemented a number of service improvements to strengthen testing pathways, reduce manual data handling, address information governance risks and resolve the texting issue.	

	• Assurance was provided that the identified issues had been addressed and that ongoing learning would be incorporated into future service improvements. **The Committee resolved that**: a) The improvements made by PHW to their Test and Post service had addressed concerns and risks related to service quality and safety was noted for assurance; b) That CAVUHB Department of Sexual Health and Safeguarding Team responded appropriately and in a timely fashion to PHW's request to review safeguarding referrals incorrectly made by PHW was noted for assurance.	
	Shaping our Quality, Value & Sustainability	
QC 26/09/6.1	*No items.*	
	Shaping our Future Clinical Services	
QC 26/09/7.1	*No items.*	
	Policies for Approval	
QC 26/09/8.1	**UHB 588 - CAVUHB Medical Gases Policy** NG provided the following summary of the Policy: - This was a new UHB-wide policy, developed in response to the Welsh Health Circular 2024 requirement for UHBs to have a robust guidance and training arrangements in place for medical gases, and in line with the NHS Health Technical Memorandum standards for medical gas pipeline systems. - The policy provided a framework for the safe management, storage, transport, prescribing and administration of medical gases. - It clarified staff responsibilities, introduced training and competency requirements, and strengthened governance arrangements through the Medical Gases Safety Group. - The policy aimed to reduce risks related to patient safety, fire, supply disruption and inappropriate storage, whilst ensuring compliance with the relevant legislation and standards. **The Committee resolved that:** A) The Medical Gases Policy for implementation across CAVUHB was approved; B) The completed Equality and Health Impact Assessment and the overall positive impact identified was noted; C) The implementation actions relating to training requirements was noted.	
QC 26/09/8.1	**UHB 132 – CAVUHB Framework for Working with Volunteers** AH provided the following summary of the Framework: • This was an updated Volunteering Framework, which focused on recruiting volunteers more strategically to support areas of greatest need and improve representation from diverse communities. • Recent progress had been made in expanding volunteer support within the Emergency Unit. • The Framework ensured that all volunteers were recruited, inducted and supported through robust governance processes. This was recognised as essential to safeguarding patients, staff and volunteers, and ensuring volunteering activity was delivered safely, consistently and effectively across the UHB. **The Committee resolved that:** A) The updated Volunteer Framework and Operational Procedure was noted; B) The findings of the accompanying EHIA 2026-29 Volunteer Framework were noted, which identified no significant adverse equality or health impacts; C) The ongoing development of volunteering opportunities that supported patient experience, community engagement and organisational wellbeing across CAVUHB was noted.	

	Items for Noting / Information	
QC 26/09/9.1	**Infection Prevention and Control (IPC) Group Minutes 16.06.2026** **The Committee resolved that:** A) The IPC Group Minutes were noted for information.	
QC 26/09/9.2	**Safeguarding Steering Group (SSG) highlight report** **The Committee resolved that:** A) The SSG highlight report was noted for information.	
	Any Other Business	
QC 26/09/10.1	*No other business was raised.*	
	Review of the Meeting	
QC 26/09/11.1	Committee members were asked to fill out the Committee Self-Effectiveness survey.	
	Date & Time of Next Meeting:	
QC 26/09/12.1	*27th October 2026 at 9am via MS Teams*	

Title	Minute Reference	Agreed Action	Executive Lead	Action Lead	Date Assigned	Date for Review	Action Status	Action Update
Acute Deterioration	QC 26/09/2.1	Bring an update on Acute Deterioration / Early Warning Scores and Call for Concern back to Quality Committee in Spring 2027.	David Fluck	Abraham Theron	29/09/2026	25/05/2027	ON FORWARD PLAN	On the Forward Plan for the 25th May 2027 Quality Committee meeting.
Health Inspectorate Wales - Estates	QC 26/09/3.5	Arrange a further strategic discussion, potentially through a Board development session, on the critical estates risks, required investment and the organisation's tolerance of those risks.	Jason Roberts	Rachel Chilcott	29/09/2026	27/10/2026	ON FORWARD PLAN	An 'Estates' item is scheduled for discussion on the 17th December 2026 Board Development meeting.
Thirlwall Inquiry: Executive Summary, Recommendations and Organisational Assurance	QC 26/09/3.6	Undertake a formal gap analysis against the 17 recommendations arising from the Thirlwall Inquiry and bring a detailed report back to Committee in November.	Jason Roberts	Jason Roberts	29/09/2026	30/11/2026	ON FORWARD PLAN	On the Forward Plan for the 30th November 2026 Quality Committee meeting.

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Cardiff and Vale University Health Board

Board Assurance Framework

Updated 24 Sep 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.

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Strategic Framework

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

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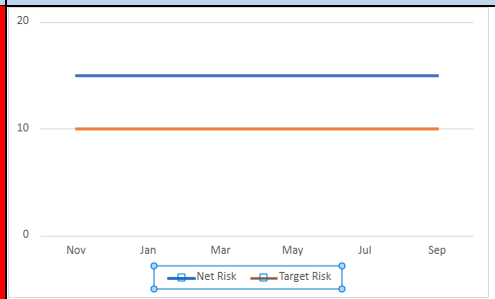
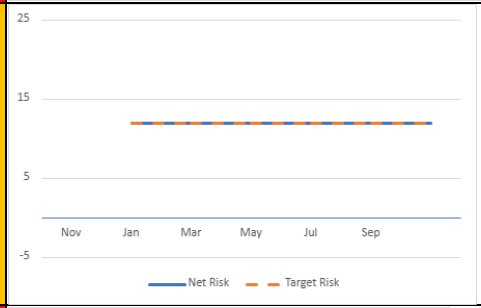
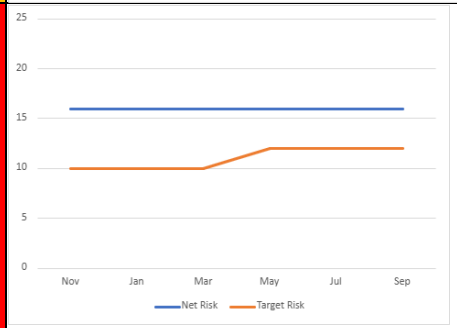
Strategic Objectives

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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

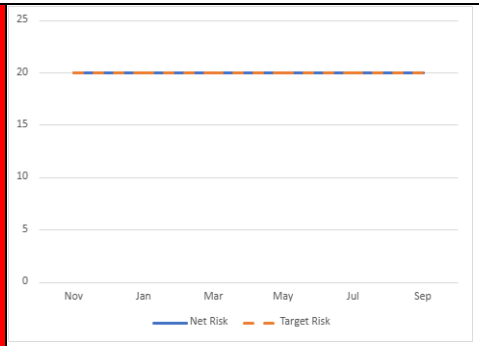
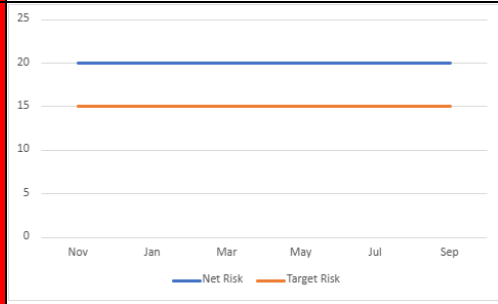
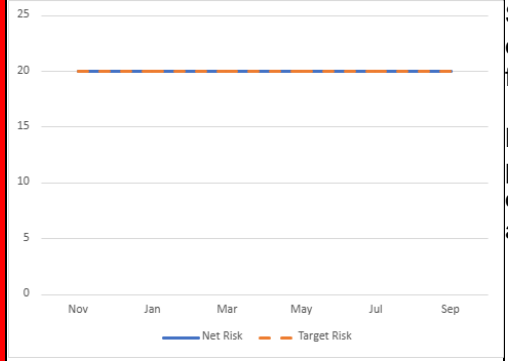
What will prevent Cardiff and Vale University Health Board from delivering its strategy?
If any of the below risk themes cannot be controlled, then the strategic objectives are unlikely to be met.

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 **12**	**20**	**16**		The most important asset of any organisation. Through the delivery of the People and Culture Plan, our strategy will be delivered with a key focus on these core People risks: Attract, Recruit, Retain | Culture | Wellbeing	Exec Dir People

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Strategic Risks – Quality

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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

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

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

Strategic Risks – Quality

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

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

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	

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Strategic Risks – Quality

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Actions			
What	**Lead**	**By**	**Update**
Deliver stroke improvement plan to address quality concerns in acute stroke pathway	PB	31/03/27	• Business case approved for stroke model, funding to be released from Q4 2024/25 • Delays in recruitment for agreed stroke post • Recruitment is now underway to the additional posts, but it will be some time before all posts are in place. There is continued focus on stroke performance and a real increase in regional working to deliver sustainable models moving forwards. • Stroke performance remains stable – new SSNAP measures to be reported to Board in August. • Go-live of phase of regional thrombectomy service in July 25 • Performance is consistent despite operational pressures. Increases in thrombolysis rates, work remains on % in time. Detailed review of thrombectomy undertaken • Stroke summit highlighted improvements in performance for some parts of pathway alongside increased challenges – particularly rehab length of stay. Work ongoing • Stroke Summit 16th June - agreed actions were to continue on all workstreams, review SRC's accommodation and clinical model and facilitate Exec colleagues' conversations with available data in the stroke dashboard.
Develop and deliver improvement plan for cancer and long waiting patients, including a plan to reduce diagnostic waiting times.	PB	31/03/27	• Delivery against revised trajectories is monitored internally and by WG • Challenging position in select specialities including ophthalmology • End of year positions in Cancer and 104 weeks for 24/25 good in comparison to recent years but still too long and not in line with WG expectations. Revised plans in place to deliver reduction during 2025/26 • Cancer performance remains best in Wales – further work to do to reach 75% • Long waits significantly reduced, meeting agreed trajectories for each quarter. • Q2 performance slightly ahead of trajectory for 104 week waits. • On-track of 450 patients waiting longer than 104 weeks by end of March. • Diagnostic challenges mean improvements will be delivered but not to the level previously expected • End of year position significantly improved for 156 weeks, 104 weeks and 8-week waits • Recurrent demand and capacity mismatches will lead to worsening of position in 26/27 without further investment • Delivering productivity and efficiency opportunities key to mitigating position • Working closely with national colleagues to maximise productivity opportunities, backlog forecast position improved from April 2026. Still expect 104-breaches in challenges specialities.

Strategic Risks – Quality

			• Non-recurrent Welsh Government funding has been provided for in year schemes against some specialities. This funding is less than requested, work underway to re-profile revised 104 end of year position.
Develop and deliver long term proposal for ITU capacity – Strategic Outline Case in production	PB	31/09/26	• The design development continues. However, discussions are ongoing with WG in relation to a combined ITU/Haematology and Hybrid theatres schemes. • Interim plan for releasing capacity on 3rd floor in progress through discretionary capital programme – work to C1 to accommodate Cardiology from C3 has commenced and is due to complete October 2025, releasing capacity ahead of the ITU work • C1 work will completed in December. Planning in place to install updated UPS • C1 work completed. UPS completed. • Detailed request for funding for C3 refurbishment, and indicating plans for subsequent A3, B3 upgrades, will be sent to WG in Q4 • Completion of proposal has been delayed due to capacity pressures, aiming for submission in Q2 26/27 • Programme Business Case will be re-reviewed at Value and Benefits Realisation Group in October.
Deliver the Theatres Together Programme which includes important quality elements such as the WHO checklist and productivity improvements	PB	31/03/2027	• Theatres Together Programme is underway, and updates provided through Board. Initial focus on 6 immediate actions and cultural priorities • Work on further tranches now underway • Progress made across programme with improvements in staff feedback. • A number of capital and estates improvements have been delivered with wider programme in development • Theatre efficiency and utilisation improvements form significant part of future work • Significant positive feedback from staff engagement sessions – indicating embedded improvements • Programme continues with an increased focus on productivity, efficiency and best practice
Review, design and improve mental health services which are noted to carry risks to quality	PB/DF	31/03/2027	• External consultancy appointed to support with review of mental health services – work ongoing • Plans for neurodevelopment services undergoing significant scrutiny • 3-year ND waits for children and young people likely to be >450 by March 2026 – working with WG and NHS P&I. • 3-year ND waits reducing for end of life but will increase in 26/27 • Implementation phase of transformation work to begin in 26/27 • Transformation plans developing and being delivered. Consideration of phase 2 opportunities from external support. Focus on out of area placements

Strategic Risks – Quality

Length of stay and continuity of care	PB	31/03/2027	• Length of stay programme in place – aiming to deliver, as a minimum, mean peer performance in medicine non-elective by the end of March 2026/27. • Performance and productivity board in place to monitor and drive change
Development of a Quality Outcomes Framework- To support a data informed approach to quality	JR/ RS	31.06.25	• Meetings underway with corporate teams to agree quality indicators • Work to extrapolate data relating to patient safety incidents commenced • Plan to develop a first draft by Q1 with digital support by June 2025 • Publication of a UHB mortality dashboard • Publication and analysis of clinical board and directorate mortality dashboards
Development of the Quality prospectus to populate the quality academy – Up skill staff across the clinical boards in patient safety review technique, improvement planning and clinical governance	JR	31.03.26	• PSLR training developed • Improvement plan training in development • Human factor prospectus planning • Development of a quality academy • Accredited audit training in place
Monitoring of the Equity, Equality, Experience and Patient Safety Action Plan and progress against actions by Clinical Boards	CB	Every six months	• Paper for Quality Committee on progress against the action plan. • Early discussions with Public health around equity measures as part of the quality outcome framework

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 insufficient investment in prevention, worsening socio-economic determinants, inequitable access and poor data limit the Health Board's ability to address inequalities, resulting in widened life expectancy gaps, higher morbidity in deprived populations and increased long-term demand on services.

Cause	Impact
Risk: a lack of investment in prevention • Our organisation aims to shift spending from reactive hospital care towards prevention and proactive care in community settings. However, secondary care continues to receive an increasing share of NHS funding, leaving prevention under-resourced. Addressing this imbalance is essential for our long-term sustainability. • There is currently a lack of capacity to deliver evidence-based interventions at scale to tackle smoking, obesity, vaccination, alcohol, substance use etc. that drive the huge disparities in health outcomes we see across Cardiff and the Vale of Glamorgan. • There is also currently a lack of capacity to undertake more substantial work on the wider determinants of health with partners, such as improving housing, educational attainment and employment. • There is currently a lack of investment in prevention: the Faculty of Public Health recommends 15 public health consultants for a population of 500,000, we employ 5.5 WTE. **Risk: worsening socio-economic determinants of health** Health inequalities are well documented across the UK and arise in multiple ways, including structural issues e.g. income, employment, education and housing and unhealthy behaviours due to the environment, social norms and income levels. Worsening socio-economic determinants in the UK are impacting on health needs and outcomes in general, but particularly for those most vulnerable in our communities.	**Impact: widened life expectancy gaps and higher morbidity in deprived populations** The risks identified above contribute to worse health outcomes and a worsening of the gap in life expectancy and healthy life expectancy between different members of our population. **Impact: increased long-term demand on services** Health inequalities are already estimated to cost £3-4 billion annually in Wales through higher welfare payments, productivity losses, lost taxes, and additional illness. The total annual cost associated with inequality in hospital service utilisation to the NHS in Wales is estimated to be £322 million, equivalent to 8.7% of the total hospital service expenses, driven largely by higher service use among people living in more deprived areas compared to those living in the least deprived (Cost of health inequality to the NHS in Wales - Public Health Wales) A lack of investment in prevention will cause an increase in future health service costs associated with health inequities. The 2026 Cost of Smoking in Wales Report highlights the significant costs of smoking - to the NHS, social care, in lost productivity and to the environment. In 2022/23, smoking cost Wales more than £1.56 billion. Nearly one-third of all smoking-related cost (£489.8 million; 31.4%) is concentrated in the most deprived fifth. Prevention funding also needs to be sustainable and planned for the longer-term so that innovative approaches to reducing health inequities, such as through the work of the Cardiff and Vale Health Inclusion Service (CAVHIS), can continue to

Strategic Risks – Health Equity

People living in the most deprived areas die earlier on average and live more of their lives in poor health; this is well recognised and deeply entrenched, but it is preventable. Risk factors interact and multiple aspects of disadvantage come together, increasing the disease burden and widening equity gaps. Moreover, disadvantage experienced in childhood is often compounded and exacerbated through adult life and therefore often passes inter-generationally. • Examples of the impacts of these inequities on health include:Areas with higher unemployment have greater incidence of suicide; and people living in the most deprived areas experience the largest increase in mental illness and self-harm. • In 2021, in England, the *undiagnosed* diabetes rate was double for those in the bottom Index of Multiple Deprivation quintile compared to the top. This presents a challenge for the NHS in finding those with an unmet need for healthcare. • Lower levels of immunisation in the population have significantly increased the risk of outbreaks of diseases like measles. These will impact disproportionately more on our most deprived communities, with direct risks to health and by further negatively impacting on wider determinants such as education or employment. • Smoking is a major contributor to health inequalities; smoking prevalence is typically higher in areas of greatest deprivation and has a significant influence on morbidity and mortality. In Wales in 2020-2022, 14.5% of deaths in adults aged 35+ and living in the most deprived areas of Wales were attributable to smoking, compared to 7.7% of those living in the least deprived areas. In Cardiff and Vale in the same period, 9.8% of all deaths in adults aged 35+ were attributable to smoking, involving 5,573 admissions to hospital. **Risk: inequitable access to services** Access to, or experience of, services, public information or healthcare sites that may be relevant / pertinent to particular health and wellbeing needs, continues to be inequitable, including as a result of discrimination. The ‘Inverse Care Law’ has been recognised for over 50 years, with those experiencing disadvantage consistently experiencing more challenges in accessing health services. Inequity of access to healthcare continues to be evident in Cardiff and the Vale of Glamorgan.	build on progress made, maximise impact and ensure that achieved gains are not reversed. Taking preventative action on health inequities can reduce premature mortality, reduce social disparities, and reduce the absolute time in ill-health for people in our communities. For example, using a NHS service such as ‘Help Me Quit’ can increase a person’s chance of successfully quitting smoking. , By locating 'Help Me Quit' clinics in areas where smoking prevalence and deprivation are highest and delivering clinics on different days and at different times of day, barriers to accessing these services can be further reduced. This preventative action can in turn reduce the burden on and costs to the Health Board and social care, while enabling our population to be more productive in our working lives. Spending on prevention has a superior return on investment when compared with acute hospital services. There is strong evidence that areas that invest more in prevention and community care see 15% lower non-elective admission rates and 10% lower ambulance conveyance rates, together with lower average activity for elective admissions and EU attendances. Changing both the distribution of resources and the operating model to deliver preventative care closer to home will also support the UHB to fulfil its organisational priorities as described in its Strategy, because they are derived from the changing needs of the population.

Strategic Risks – Health Equity

Risk: limited and poor quality data

Evidence suggests that key population groups with multiple vulnerabilities include:

- Some people in minority ethnic groups, especially some people in Black and Asian populations
- People living in (or at risk of) deprivation and poverty
- People in insecure/low income/informal/low-qualification employment, especially women.
- People who are marginalised and socially excluded, such as people experiencing homelessness and other inclusion health groups

However the quantity and quality of data on the health needs, outcomes and experiences of people from these and other disadvantaged groups is highly limited. This impacts on our ability to both understand and mitigate health inequities using evidence-based and effective approaches.

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.	Board papers Committee papers to Quality Committee e.g. updates on Equity, Equality, Experience and Patient Safety Framework. Committee papers to People and Culture and Quality and Safety Committees e.g. updates on Welsh Language Standards. Risk Registers Integrated Performance Report Papers to Senior Leadership Team (SLT)

Strategic Risks – Health Equity

- All our Executives have taken up a leadership role as an Inclusion Ambassador covering different characteristics, including those specified in the Equality Act 2010.
- The Head of Equity and Inclusion is a member of the Public Sector Equality Network, improving the collaboration between public sector organisations in the area. The UHB also now has an Equity & Inclusion Manager, together supporting Clinical and Service Boards, including with awareness and training on completing Equality Impact Assessments.

3. Our Strategy and plans

- The refreshed UHB Strategy 'Shaping our Future Wellbeing' shines a light on the issue of equity at the strategic level.
- 'Shaping our Inclusive Culture 2024-2028' is closely aligned with the UHB's Strategy 'Shaping our Future Wellbeing'.
- The Cardiff and Vale Long-term Public Health Plan 2024 – 2035 sets out how the UHB intends to achieve its ambitions of increasing life expectancy, reducing inequity and shifting more focus to prevention.
- Through our Public Services Board (PSB) and Regional Partnership Board (RPB) plans we already prioritise areas of work to tackle inequalities and the refreshed needs assessments for both PSBs and RPB have further identified collective actions.
- The future UHB organisational direction supports the 'shift upstream' by committing to develop an Integrated Community Health System, underpinned by care pathways that begin with prevention; prevention is a 'brilliant basic'.
- An 'Equity, Equality, Experience and Patient Safety' action plan was approved by Board in May 2024, covering 24 initial actions across the Clinical Boards that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. Progress on actions is reported to Quality Committee on a 6-monthly basis (most recent update provided in April 2026). Ongoing review is undertaken to identify outstanding actions and create future actions using the framework.

4. Public Health priorities to reduce health inequalities

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

- preventing obesity (focus 0-5 years)
- reducing smoking rates
- increasing levels of vaccination (using an outreach model to reduce inequity in uptake).

These priority areas are being developed through UHB-wide work, including:

Strategic Risks – Health Equity

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

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

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	• 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

suite of focused preventative actions to tackle inequalities in health.		annual actions 2026/2027	this work were presented to the Quality Committee in April 2026 and the next update on this work will be presented in a further 6 months. • Innovative approaches to help people quit are being trialled, such as the 'Allen Carr Easyway to Stop Smoking' method. The 'Help Me Quit' team has also begun working with Cardiff People First, trialling an approach to help people with a learning disability quit smoking. • As part of the All-Wales Accessible Communication and Information Standards, the UHB has developed an Accessible Communication Policy. This policy has now been signed off by the Board. The Patient Experience Team are also currently working closely with the Professional Standards Nursing Team to develop and audit a tool for clinical teams to use to assess their area's compliance with the all-Wales Accessible Communication and Information Standards. This is currently being piloted in selected areas. • In the Cardiff City and South Primary Care Cluster of Cardiff, focused work has begun to understand barriers to vaccination uptake. A survey was launched in May 2026 translated into five community languages (alongside English and Welsh) and will run until the end of August. It is being shared via community networks and by health visitors as part of their immunisation conversations. This, alongside targeted engagement, will inform interventions to increase vaccination uptake in an area that consistently has the lowest levels within the Health Board area. Targeted engagement this period has included a stakeholder workshop in Grangetown in July with representatives from the public health team, primary care, health visiting, school nursing and community leaders. This has led to recommendations for action which will inform the refreshed Vaccination Equity Strategic Plan. A follow-up workshop is planned for September. • The Childhood & Teenage Immunisations Strategic Action Plan has been approved by the Strategic Immunisations Group and will be reviewed by the Quality Committee in October. Equity is a cross-cutting theme of this. • CAVHIS appointed 1.5 WTE Mental Health Practitioners in July 26, providing onsite specialist assessment and support for newly arrived people seeking asylum and refuge. These roles allow care to be given 'closer to home' and are expected to result in reduced crisis presentations and improved outcomes for patients. Planned actions: • Refresh sections of the Population Needs Assessments or undertake Health Needs Assessments for 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.
Advocate for more resources for prevention as a percentage of the total health board budget.	Claire Beynon	2026/2027	• Continue to advocate for increased resources for prevention to improve the health and wellbeing of the local population. • Ongoing work on the business plans that would allow full implementation of evidenced based interventions to reduce health inequalities for smoking and obesity, to include time frame for benefits.

Strategic Risks – Health Equity

			• 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 report . • 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

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

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

Strategic Risks – People

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

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

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

Strategic Risks – People

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

Strategic Risks – People

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

Strategic Risks – People

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

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

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

Strategic Risks – People

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

Strategic Risks – People

			Committee in Sept 26, seeking Board approval for the 2-3 priorities that need to be prioritised.

Strategic Risks – Digital

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

Risk

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

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

Strategic Risks – Digital

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

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

Strategic Risks – Digital

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

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

Actions			
What	**Lead**	**By**	**Update**
Internal investment case to support the Digital Foundations case approved	Director of DHI	Mar 26	Programme Business Case completed and shared with WG setting out detailed roadmap plans and the associated costs, funded accessed by annual Business Justification Cases to WG's Major capital budget. Statement of works produced against which a suitable external partner will be sought Digital Foundations Programme Business Case and supporting Business Justification Cases for Year 1 (of the 5 year case) complete. PBC being taken through the internal governance process comprising Capital Management Group, Value & Benefits Realisation Group, Senior Leadership Team, F&P and D&I committees before presenting to the November Board meeting and thereafter submission to Welsh Government for their consideration/approval. The existing Digital Foundations PBC seeks funding from the all Wales major capital budget but has a revenue tail which is currently unfunded. additional work is taking place, including detailed discussion with each Clinical Board, to identify the funding source to enable the PBC to progress through internal CAV UHB governance process – this will likely not happen until the new financial year. May 26: Meeting with WG's Head of Capital, CAV DoF and CAV DoD took place on 13/05/26 to provide update and share summary information in advance of a formal submission if agreed by CAV Board following due governance process. July 26: Capital bids invited by WG specifically to address Estates Backlog and DIgital Maintenance (back-log) costs, resulting in CAV submitting a digital maintenance bid for £7.8m in June 2026. There has been no further update on the consideration of the Digital Foundations PBC and associated year 1 BJCs submitted earlier in the year.
Development of the Digital Programme Business case to support the digital foundations ambitions is underway.	Director of DHI	May 26	External partner identified and service procured which has enabled the works to commence on the Programme Business Case. Co-production approach with all Clinical Boards and corporate services involved via workshops taking place during May and June 2025.

			July 25: Draft plans and outputs from workshops shared with Clinical Boards for comment prior to feeding into the Programme Business Case in Sept/October 25. Digital Foundations work to support the development of the Programme Business Case and supporting Year 1 Business Justification Cases complete. Workshops held with input from all Clinical Boards and services to ensure full co-production and alignment with the organisation's strategic objectives. Nov 25: Further scoping and detailed workshop being held with each Clinical Board during November and December to capture the detail of where savings can be made arising from automation and digital changes which will be used to off-set the revenue shortfall. The DF PBC has been shared with digital team at WG following the Digital presentation made at the November IQPD meeting. The intention is to submit the final case to Board for approval prior to formally submitting to WG for consideration via the Infrastructure Investment Board Jan 26 – additional work to identify the funding source for the associated revenue costs – especially in year 1 of the PBC means that the process will slip into 26/27. Decisions on allocating WG major capital are not expected until well into Qtr 1 26/27. May 26: An updated PBC and Year 1 BJCs have been developed and are in the process of working through the internal governance process having been reviewed by the D&I committee, SLT and Value & Benefits Realisation Group and Capital Management Group, with the case to be considered at the Finance & Performance Committee prior to submission to Board on 28/05/26. July 26: Audit Wales have completed their audit into CAV's Digital Transformation, resulting in 8 specific recommendations: Strengthen strategic delivery and affordability Develop the Board's understanding of Digital Improve assurance over digital and cyber risks Establish a clear approach to AI Build workforce readiness for digital transformation Have clear contingency plan for funding digital transformation Embedding how it works with staff and patients in its digital developments Reporting on digital programme benefits The management response to the above recommendations sets out the actions to be taken, which will be shared in more detail at the D&I committee meeting in August 2026.

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

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

Uncontrolled Risk

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

Strategic Risks – Infrastructure

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

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

Strategic Risks – Infrastructure

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

Strategic Risks – Infrastructure

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

Strategic Risks – Sustainability

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

Risk

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

Cause	Impact
Decarbonisation and Climate	
The world has breached the 1.5°C pathway set by the Paris Agreement in 2024. Growing evidence shows that the magnitude of climate impacts is increasing day by day, and Cardiff is projected to be one of the most affected cities in the UK.	Interim findings from the 2026 Heatwave Staff Impact Survey demonstrate the growing impact of extreme heat on workforce wellbeing, productivity, and healthcare delivery. A total of **91.8% of respondents reported poor comfort levels**, **88.5% reported reduced productivity**, and **35.4% experienced heat-related illness** during heatwave conditions. Among clinical respondents, **43% reported increased patient footfall** and **42.5% reported increased patient length of stay** during periods of extreme heat. Combined with climate projections indicating more frequent and severe heatwaves, these findings emphasise the need for accelerated adaptation measures to protect staff, patients, and service resilience. Both of the above factors present a financial risk.
In 2024-25 the UHB's emissions increased by 44% to c260,000 Tons of Co2 compared to 2023-24 emission of c180,000.	The UHB has already missed Welsh Government target of reducing its emission by 16% by 2025. CAV UHB does not have a line of sight to achieve the 40% reduction in directly controlled emissions required by the strategy by 2027 nor the 34% emission by 2030. (from a 18/19 baseline).
Currently, UHB has undertaken an initial climate risk assessment however a comprehensive assessment of current and future climate risks is yet to be conducted.	This renders UHB vulnerable to unidentified climate risks that have a direct impact on healthcare delivery and its financial situation.

Strategic Risks – Sustainability

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

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

Strategic Risks – Sustainability

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

Strategic Risks – Sustainability

Risk Post-Controls and Mitigation			
Impact: 4	Likelihood: 5	Net Risk: 20	
Actions			
What	**Lead**	**By**	**Update**
Procure consultant programme management and turnaround capability to increase pace on the IY savings plan	A Gough	Sep 26	PWC awarded 12-week contract and in situ

Report Title:	Discharge Advice Letters (DALs) update		Agenda Item No:		3.1
Meeting:	Quality Committee	Public	X	Meeting Date:	27.10.2026
		Private			
Lead Executive Title:	Executive Nurse Director / Executive Medical Director				
Report Author/s Title:	Associate Medical Director Patient Safety and Clinical Effectiveness				

Report Focus Summary – **AAA Framework:**

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

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

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

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

Discharge advice letters (DALs) are now fully generated within ePMA. Discharge Advice letters have benefited from an operational change meaning that they cannot be left in draft in the ePMA system. DAL completion rates are being live monitored by the development of a dashboard in ePMA allowing Clinical Boards and Directorates to interrogate data in relation to DAL performance. There is ongoing work to maximise DAL completion, improve DAL quality and to provide all patients with a copy of their DAL.

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

Recommendations

The Committee is asked to:

- Note that recurrent updates are no longer required, while ongoing monitoring of DAL performance and quality will continue**.**

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

***Where** it's been:*	*DAL Group – reports to Clinical Safety Group*
***When** it went:*	*DAL Group meets quarterly*
***What** decision was made:*	*This update to Quality Committee requested from previous quality meeting*

Main Report

Background & Current Situation

Discharge Advice Letters have been identified as a clinical risk across health systems internationally. A Discharge Advice Letter (DAL) is a clinical document for the communication of information on transfer of care of an individual from the inpatient hospital setting. A DAL describes the diagnoses and care provided to individual patients during their hospital stay, the treatments provided, and the medications added, changed, or stopped during the inpatient spell. The DAL should provide accurate information on salient investigations undertaken, critical information for the patient and GP, and any necessary follow-up within the system. A DAL can also allow prescription of take home Medicines. Many problems are known to exist across NHS systems regarding the completion

of DALs, the quality of information within a DAL, the provision of Medicines at the correct dose, as well as the physical sending and receipt of a DAL. It has become clear that there are multiple, cross system, digital, cultural, historical, interdependent, issues at play.

One issue significantly hampering DAL communication in Cardiff and Vale's (CAV) digital systems was the necessity to generate a DAL in Welsh Clinical Portal (WCP). This meant that DAL data was held centrally by Digital Healthcare Wales (DHCW). Data on DAL generation was difficult to obtain from DHCW, and when obtained difficult to make sense of to feed back to Clinical Boards and Directorates in relation to performance. The decision to generate DALs in ePMA has resulted in CAV owning our own DAL data. The ePMA team have developed an interactive DAL dashboard which can be viewed here. This extremely useful tool will allow Clinical Board and Directorate teams, as well as individuals undertaking QI work, to understand and track DAL data in a live reporting environment – thereby optimising DAL performance.

On September 1st 2026 a change was enacted honouring a collective decision made in the Clinical Board Directors meeting to end the ability for a DAL to remain "in draft". The option for DALs to remain in draft was peculiar to CAV systems, not being available to other health systems running ePMA DALs. This change has meant that a DAL should be signed off clinically before take home medicine can be dispensed. This decision was implemented seamlessly and does not appear to have materially affected patient flow. This change is a positive step in promoting DAL production prior to the discharge of a patient from the ward environment.

Despite these changes there is still much work to do in order to maximise DAL completion and optimise DAL quality. Work is ongoing to ensure that DAL completion rates are optimised – for example, in areas where patients do not need take home medicines or where take home medicines are provided from ward areas.
In respect to DAL quality Secondary care clinicians continue to work with Primary Care colleagues to ensure that Resident Doctors are well informed as to the type of information most needed on transfer of care, and conversely the information less appreciated and less warranted.

In line with a Welsh Health Circular there is ongoing work to provide a paper copy of the DAL to the patient on leaving the ward environment. This already happens in some ward areas but is not yet universal behaviour for a number of technical and administrative reasons.

Discussions on the further optimisation of DAL completion and quality will continue to be discussed in the DAL group – a multiprofessional group, chaired by the AMD for patient safety, and attended by engaged colleagues from throughout primary and secondary care within CAV. The DAL group will currently report and escalate through the Clinical Safety Group.

Appendices:

n/a

Strategic Alignment – Shaping Our Future Wellbeing:

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

Impact Assessment

Risk: No

No risk assessments required – see previous DAL papers to quality committee for full assessment of risks associated with Poor DAL completion rates and poor DAL quality.
Safety: Yes
Optimisation of DAL completion improves patient safety on transfer of care between healthcare settings.
Financial: No
Workforce: No
Legal: No
Reputational: Yes
Mitigation provided within reported DAL improvements against reputational risk from potential concerns and claims in relation to lack of DAL completion and poor DAL quality.
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: No
Decarbonisation: Yes
In future one would hope that a copy of the DAL to the patient could be provided digitally and not as a paper copy.
Welsh Language: No
DALs not currently generated in the Welsh language.

Report Title:	Update on Fuller Report recommendations		Agenda Item No:		3.2
Meeting:	Quality Committee	Public	X		27.10.2026
		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:**

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

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

The UK Government update of 15 July 2026 confirms that the majority of the 75 Fuller Inquiry recommendations have been accepted in full, with further work continuing on recommendations requiring assessment of practicality, cost, proportionality and deliverability.

For NHS mortuaries, national action is focused on strengthened security, governance, accountability and safeguarding. Locally, the gap analysis against recommendations 1–21 has been updated. Most controls are in place or progressing, with residual dependencies relating to capital works, compliant winter body-storage capacity, and safeguarding arrangements.

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

Recommendations for the Committee:

1. **Note the UK Government update of 15 July 2026 and the national direction for strengthened mortuary security, governance, accountability and safeguarding.**
2. **Note the evidence of substantial local progress against Fuller recommendations 1–21.**
3. **Acknowledge the mitigations related to safeguarding arrangements.**
4. **Note the review of the Ockenden recommendations in relation to maternal, fetal and peri-natal care after death**
5. **Support continued oversight through Quality Committee, with a further update following confirmation of completed works or via annual regulatory compliance report for all regulated activity in CD&T clinical board which would include mortuary activity**

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

***Where** it's been:*	*Quality Committee*
***When** it went:*	*June 2026*
***What** decision was made:*	*Recommended to come to Quality committee for further updates*

Main Report

Background & Current Situation

Purpose

This report provides Quality Committee with an updated position on implementation of the Fuller Inquiry recommendations relevant to NHS mortuaries and body stores. It incorporates the UK Government statement of 15 July 2026 and the latest local update on outstanding capital-dependent security controls.

In addition, and following the publication of the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust that relate to maternal, fetal and perinatal care after death; a gap analysis has been undertaken against the recommendations made by Donna Ockenden

National position

The Fuller Inquiry Phase 2 final report was published on 15 July 2025 and made 75 recommendations to strengthen the security and dignity of people after death across a wide range of settings. In its statement of 15 July 2026, the UK Government confirmed that it had accepted in full the majority of Sir Jonathan Michael's recommendations and was progressing a substantial programme of work with NHS England, the Human Tissue Authority, the Local Government Association and other partners.

The statement reports significant progress for NHS hospitals, including actions at NHS Board level to strengthen mortuary security and wider governance, accountability and safeguarding arrangements.

Local scope and assurance

Recommendations 1–21 relate specifically to NHS mortuaries and body stores. Recommendations 1–9 concern the NHS estate, while recommendations 10–21 focus on governance, accountability and safeguarding. A comprehensive local gap analysis and evidence-of-conformance record has been maintained and updated.

There is strong evidence of established controls, including CCTV coverage, routine access and CCTV audits, controlled individual swipe-card access, quarterly review of access permissions, incident reporting arrangements and governance through the HTA Compliance Group and Clinical Board quality structures.

Outstanding capital-dependent controls

Outstanding estate actions include changes to TDSI access to support swipe-in and swipe-out monitoring, additional CCTV coverage and a physical contingency lock (as contingency to TDSI failure) for the UHW body store. Open view order raised and IP addresses requested, install planned for end of October 2026. The latest service update confirms that the physical lock has been included in the capital programme and should also be in place by end of October

Capacity and continuity risk

A plan for additional compliant refrigeration capacity at UHW to support during Winter has been developed through an SBAR and is progressing through procurement and finance.

Governance and safeguarding

The HTA Compliance Group reports through the Clinical Board governance structure. Fuller recommendations 15 and 18 require routine formal reporting on mortuary services to the Board or an appropriate Board committee, including staffing, security incidents, serious incidents, HTA matters and security audits. An annual report of all regulated activity in Clinical Diagnostics & Therapeutics Clinical Board to be provided to committee in February 2027 and will include all mortuary services as described in the recommendations

Recommendation 19 requires the security and dignity of deceased people to be reflected in safeguarding training, policies and assurance. Public Health Wales are reviewing level 1 and 2 ESR safeguarding training and looking to include security and dignity of the deceased when it is updated for All Wales. In the interim Head of Safeguarding is drafting a short briefing for all staff to highlight need for dignity in death

Ockenden-related review

The mortuary team have reviewed the recommendations arising from the Independent Review of Maternity Services at NUH that relate to maternal, fetal and perinatal care after death. The review records established controls for post-mortem location, reconstruction, professional registration and competency, with further work progressing to evidence full HTA-aligned practice and audit arrangements within the fetal pathology unit.

Next steps

The Clinical Board will continue to seek confirmation of CCTV and TDSI works; progress the compliant winter-capacity plan; monitor safeguarding developments; continue to work through the Ockenden recommendations, tracking progress through HTA compliance group.

Conclusion

In conclusion, the Clinical Board can demonstrate substantial progress against the Fuller Inquiry recommendations and those of Donna Ockenden in relation to maternal, fetal and perinatal care after death. Quality Committee is asked to note the progress made, recognise the residual dependencies and support continued oversight through the HTA Compliance Group, Clinical Board governance structures and future annual regulatory compliance reporting.

Appendices:

n/a

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

The principal residual risks concern reduced winter body-storage capacity following withdrawal of the non-conforming temporary unit, and dependency on capital delivery for outstanding security controls. These risks and mitigations are described in the main report.

Safety: No

Financial: Yes

Capital expenditure is required for outstanding security improvements, including the physical contingency lock, TDSI swipe-in/swipe-out changes and additional CCTV coverage. The compliant winter-capacity plan is also progressing through procurement and finance.

Workforce: No

Legal: No

Reputational: No

Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*

Equality & Health: No

Decarbonisation: No

Welsh Language: No

Report Title:	Looked After Children Backlogs Update		Agenda Item No:		4.1
Meeting:	Quality Committee	Public	X	Meeting Date:	27.10.2026
		Private			
Lead Executive Title:	Executive Nurse Director				
Report Author/s Title:	Becci Ingram, General Manager, CYPFHS				

Report Focus Summary – **AAA Framework:**

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

This report provides assurance around the continued improvements in respect of Health Assessments for Children Looked After.

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

Recommendations

The Committee is asked to:

1. Note the update on Children Looked After.

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 purpose of this report is to provide Committee Members with an updated position regarding health assessments for Children Looked After (CLA) across Cardiff and the Vale of Glamorgan.

As previously reported, there has been a sustained increase in the number of children entering care across Cardiff and the Vale of Glamorgan. This growth has had a significant impact on demand for both Initial Health Assessments (IHAs) and Review Health Assessments (RHAs), resulting in increased waiting times and challenges in meeting statutory requirements.

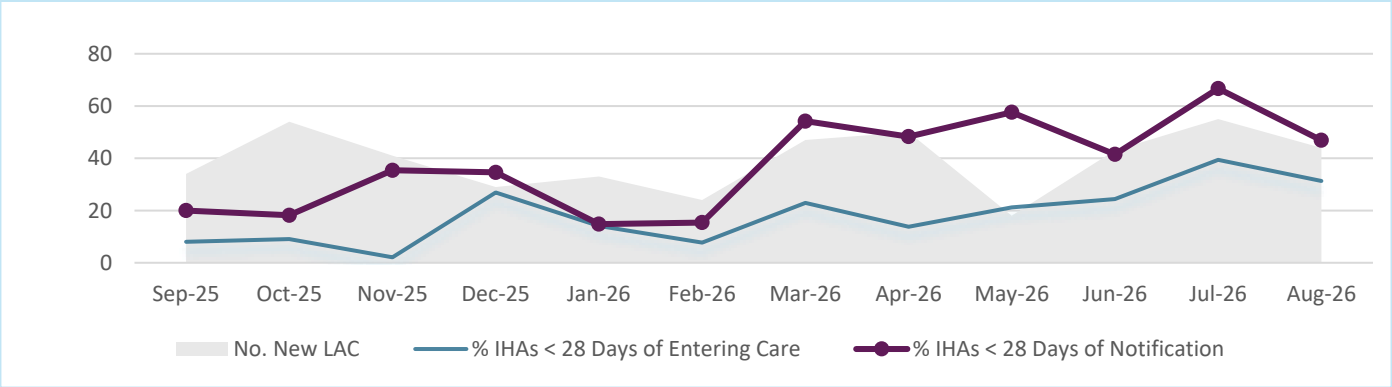
Over the past three years, a programme of significant service transformation has been implemented to address these pressures. These changes have resulted in a substantial reduction in the backlog of health assessments and an improvement in compliance with statutory timescales.

Statutory guidance requires that a comprehensive health assessment is completed within 28 days of a child entering care. Thereafter, Review Health Assessments must be undertaken every six months for children under five years of age and annually for children aged five years and over.

- **Initial Health assessments**

Initial Health Assessments are undertaken by medical staff for children under five years of age and those with adoption plans, and by specialist nurses for children aged five years and over.

Graph 1 – Percentage of initial health assessments (IHA) completed within 28 days of entering care, and within 28 days of notification, and backdrop of new accommodations



The data demonstrates continued improvement in the proportion of Initial Health Assessments completed within 28 days of notification. However, delays in notification from the point at which a child enters care continue to impact overall performance against the statutory requirement of completing assessments within 28 days of accommodation.

There has been a sustained increase in the number of Initial Health Assessments completed over the last three years, reflecting the growth in the number of children entering care. Medical capacity remains a significant challenge, with the service reliant on a small specialist workforce. During this period, staffing capacity was further affected by the retirement of an experienced clinician and a period of maternity leave for another practitioner. Consequently, the service experienced several months of reduced medical capacity.

To mitigate these pressures, the role of trainee medical staff has been reviewed and enhanced to include dedicated assessment sessions for children under five years of age, supporting improved service resilience and capacity.
The graphs below demonstrate the increase in Initial Health Assessments undertaken and the associated reduction in the backlog of assessments, both for children placed within Cardiff and the Vale and for those placed outside the area.

Graph 2 – Number of initial health assessments undertaken

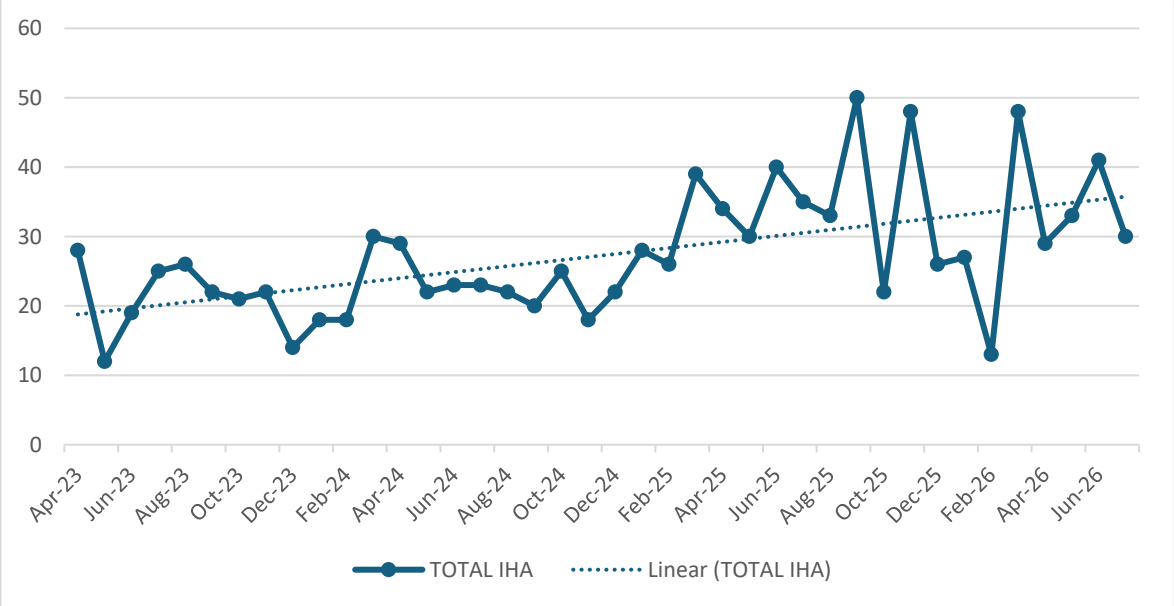
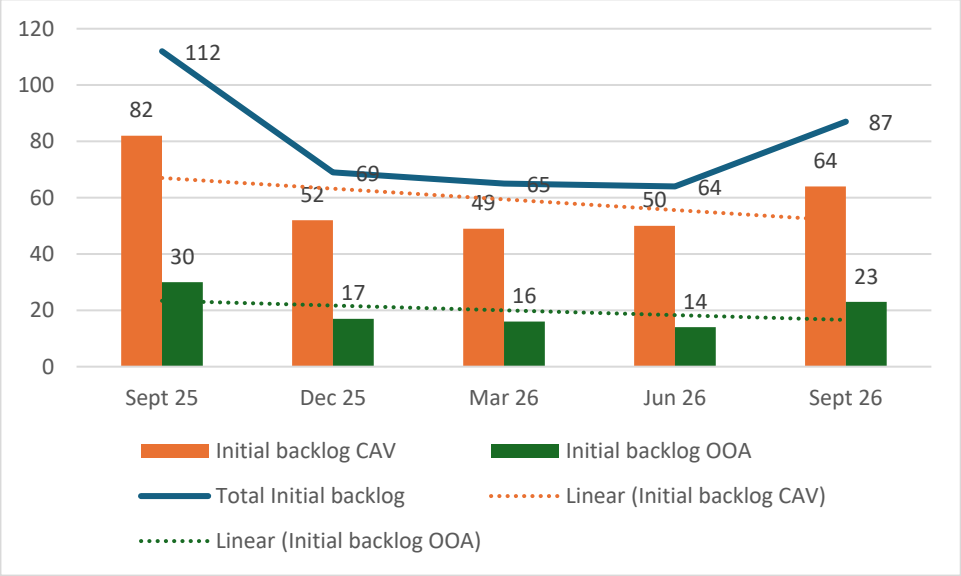


Figure 3 – Backlog of initial assessments



It should be noted that there was a slight increase in the backlog during the reporting period. This reflects the higher volume of new accommodations between July and September 2026 compared with the period from April to June 2026.

➢ **Review Health Assessments**

Significant service redesign has been undertaken over the past three years to address the increasing number of Children Looked After awaiting Review Health Assessments.

Key changes include;

- Nurses are now undertaking all initial and review health assessments for children over 5 (excluding adoptions).
- Health Visiting roles were initially piloted to undertake Review Health Assessments for children under five years of age (excluding those placed for adoption). Whilst successful initially, the increasing number of children entering care and the growing complexity of their needs resulted in these dedicated caseloads becoming unsustainable. To mitigate this risk and improve service resilience, it has been agreed that Review Health Assessments for children under five will be delivered through the wider Health Visiting workforce. All Health Visitors will be trained and supported to undertake these assessments, with compliance monitored

through operational management arrangements. Robust quality assurance processes will also be implemented to ensure consistency and maintain standards of care.

The graphs below demonstrate the increase in Review Health Assessments completed and the corresponding impact on the assessment backlog. Whilst there has been a reduction in the backlog for children placed within Cardiff and the Vale, a small increase has been observed for those placed outside the area.
The Team Leader retains responsibility for monitoring the health needs of children placed out of area and continues to work closely with host Health Boards and Trusts to ensure that statutory health assessments are completed within required timescales. Although children may be placed outside Cardiff and Vale, statutory responsibility for ensuring completion of health assessments remains with Cardiff and Vale University Health Board.

Graph 4 – Number of review health assessments undertaken

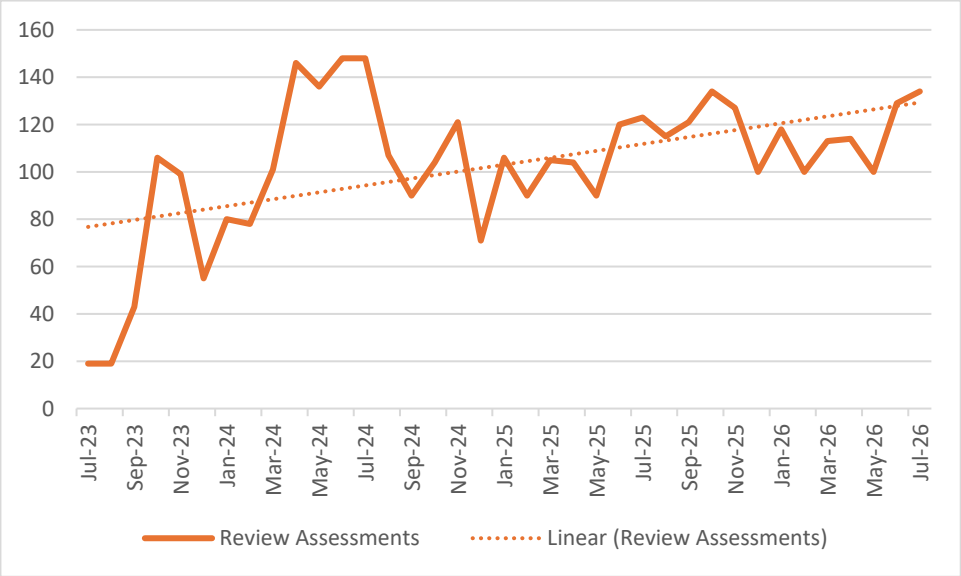
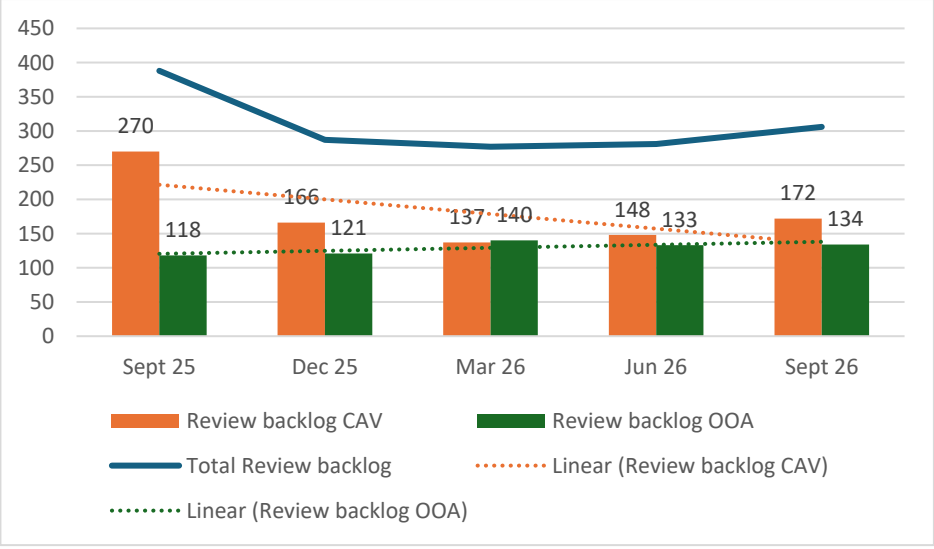
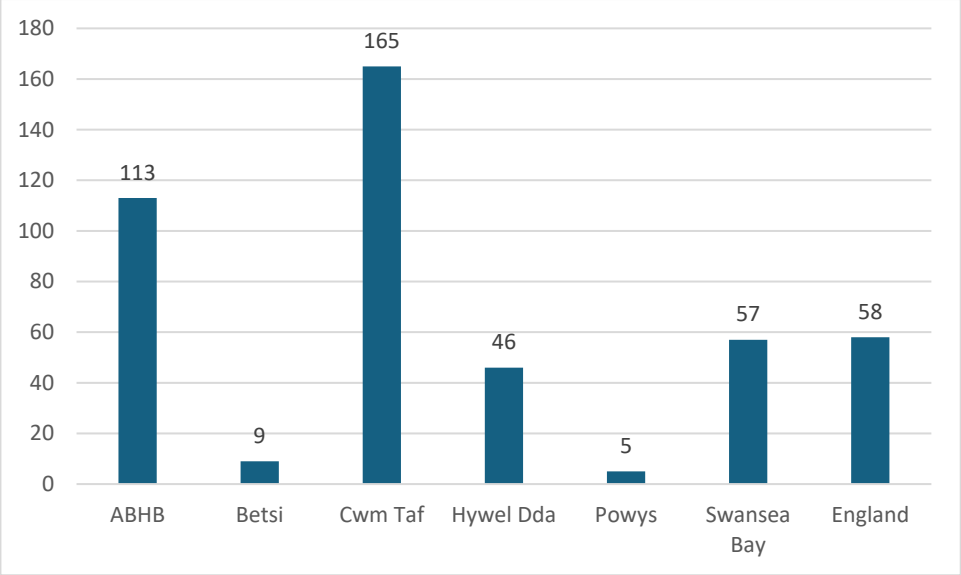


Figure 5 – Backlog of review assessments



- **Children placed out of area**

Graph 6 – breakdown of children placed out of area



Where children are placed outside the Cardiff and Vale region, health assessments are generally undertaken by the host Health Board or NHS Trust. These organisations subsequently recharge Cardiff and Vale University Health Board for the cost of delivering this statutory provision, with the average cost per assessment being approximately £400.

The Health Board currently incurs expenditure of approximately £0.2 million per annum in relation to these externally commissioned health assessments.

In addition to health assessments, Health Boards are increasingly invoicing for a broader range of healthcare services provided to children placed out of area, including Accident and Emergency attendances, inpatient admissions, and Child and Adolescent Mental Health Services (CAMHS) interventions.

There is currently significant variation in charging arrangements and associated costs across Health Boards. This matter has been escalated to the Finance and Commissioning Team for further discussion with partner Health Boards to ensure greater consistency, transparency and value for money.

Overall Summary

The service has delivered significant improvements in reducing the backlog of statutory health assessments despite continued increases in the number of Children Looked After. Whilst challenges remain, particularly in relation to medical workforce capacity, notification delays and out-of-area placements, the service redesign undertaken over the last three years has strengthened capacity, improved compliance, and placed the service on a more sustainable footing to respond to future demand.

Appendices:			
n/a			
Strategic Alignment – Shaping Our Future Wellbeing:			
Putting People First	✓	Providing Outstanding Quality	✓
Delivering in the Right Places		Acting for the Future	

Impact Assessment
Risk: Yes
Risks surrounding CLA Health Visiting caseloads identified and changes made as highlighted in report.
Safety: No
Financial: Yes

Increasing costs associated with Children from Cardiff and Vale being placed out of area as highlighted in the report.
Workforce: Yes
Health Visiting (as above) *Medical capacity identified as a constraint. Changes made to trainees job plan to undertake initial health assessments for children aged 5 and under.*
Legal: No
Reputational: No
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Report Title:	Eating Disorder Service Review Update			Agenda Item No:	5.1
Meeting:	Quality Committee	Public	X	Meeting Date:	27.10.2026
		Private			
Lead Executive Title:	Chief Operating Officer				
Report Author/s Title:	Interim Director of Psychology for Mental Health Clinical Board				

Report Focus Summary – **AAA Framework:**

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

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

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

The Tier 3 Eating Disorder Service improvement programme has delivered significant progress in governance, leadership, multidisciplinary working, workforce recruitment and clinical oversight. Weekly MDT caseload reviews, escalation arrangements, supervision processes and assurance meetings have been established, alongside strengthened medical and psychological input. A September 2026 review of active cases demonstrated improved scrutiny and transparency regarding clinical risk across the service.

The review confirmed that many patients continue to present with high levels of clinical risk and identified variation in the consistent application of core clinical controls across the caseload. Gaps remained in physical health monitoring, documentation and evidence of treatment offers aligned to national guidance. Whilst workforce capacity has improved through recruitment and strengthened medical provision, outstanding clinical risks remain and further improvement is required to ensure that all elements of care are consistently embedded and evidenced.

As of 13 October 2026, the service held 51 open Tier 3 cases, comprising 37 Cardiff and Vale patients and 14 Cwm Taf Morgannwg patients. There was no waiting list, and all referrals were assessed within 28 days. Continued senior oversight, audit and monitoring remain necessary to provide assurance that improvements are sustained and reliably embedded across the service.

Rationale for Advise Rating:

Progress has been achieved through strengthened governance, leadership, staffing, multidisciplinary oversight and improved escalation arrangements. However, assurance remains qualified because the September review identified that key clinical and operational controls are not yet consistently embedded across the caseload, particularly regarding physical health monitoring, documentation, accountability and delivery of nationally aligned treatment pathways. Further monitoring and demonstrable evidence of embedded improvement are required before full assurance can be provided. The Board is therefore advised of progress made, residual risks and ongoing actions required to achieve sustainable improvement.

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

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

Recommendations for the Committee:

1. **Note** the progress made within the Tier 3 Eating Disorder Service improvement programme, including strengthened governance, leadership, workforce recruitment and multidisciplinary oversight.
2. **Note** the findings of the September 2026 assurance review and the continuing requirement to strengthen consistency in physical health monitoring, clinical documentation and treatment pathway delivery.
3. **Receive assurance** that identified risks are being actively monitored through the established governance framework, risk register and improvement programme.
4. **Note** that continued senior oversight, repeated audit activity and evidence of completed patient-level actions will be required before full assurance can be achieved.

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 Tier 3 Eating Disorder Service has been undertaking a comprehensive improvement programme in response to previous workforce, governance and service delivery challenges. Improvements have focused on strengthening governance arrangements, multidisciplinary clinical oversight, escalation processes, supervision structures and leadership accountability. Dedicated medical provision, consultant psychiatric support and additional recruitment across dietetics, occupational therapy, psychology and administration have strengthened service capacity.

Reviews of historical incidents, complaints and patient discharges identified workforce pressures as a significant contributory factor. Although no new themes, significant incidents or complaints have emerged in recent months, a further detailed review of ten patients was undertaken in September 2026 to provide additional assurance regarding current service delivery and risk management.

The review demonstrated improved oversight and understanding of risk across the service. It confirmed that many service users continue to present with significant clinical complexity and high levels of risk. Whilst core elements of care planning, multidisciplinary involvement and risk assessment are established for many patients, practice is not yet consistently embedded across the entire caseload. Variability remains in physical health monitoring, documentation standards and evidence of treatment offers aligned with national guidance.

The review further confirmed that workforce strengthening alone does not resolve all outstanding clinical risks and that ongoing action is required to ensure consistent implementation of clinical controls, robust accountability arrangements and sustained improvements in service delivery. Priority actions remain focused on physical health monitoring, clarification of clinical accountability, strengthening of documentation, review of diagnosis and consent processes and development of treatment pathways aligned with national standards.

As of 13 October 2026, there were 51 open Tier 3 cases, with no waiting list and all referrals assessed within 28 days. Governance arrangements provide reassurance that risks are being identified, escalated and actively managed; however, assurance remains qualified until

improvements are demonstrably embedded and sustained. The service therefore remains subject to enhanced oversight through the improvement and assurance programme.
Appendices:
n/a
Strategic Alignment – Shaping Our Future Wellbeing:

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

Impact Assessment:
Risk: Yes
Workforce instability remains the principal risk to SHED service resilience. This is monitored through the Mental Health Clinical Board risk framework and mitigated through strengthened leadership, weekly MDT risk reviews, enhanced medical cover, active recruitment, operational oversight and formal escalation.
Safety: Yes
Improved clinical oversight, multidisciplinary working, medical cover and governance provide assurance that patient safety risks are being managed. Workforce pressures remain, but mitigation plans are in place and recent reviews have identified no new safety themes.
Financial: Yes
Costs associated with recruitment, enhanced medical provision and project management support are being managed through existing workforce and service improvement arrangements.
Workforce: Yes
Workforce instability continues to challenge but are being managed. Recruitment has progressed across psychology, dietetics, occupational therapy and administration, with ongoing workforce planning and organisational development supporting sustainable delivery.
Legal: No
Pre-existing governance, complaints and risk management processes continue to operate within established legislative and regulatory frameworks.
Reputational: Yes
Reputational risks are mitigated through strengthened governance, transparent oversight, active complaints management, improvement actions and senior leadership monitoring.
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
The improvements described support equitable access to specialist eating disorder services and the delivery of care for vulnerable individuals across Cardiff and Vale and Cwm Taf Morgannwg.
Equality & Health: No
No Equality and Health Impact Assessment is required. The service remains committed to providing equitable access to specialist eating disorder care and continues to monitor delivery through established governance arrangements.
Decarbonisation: No
There is nothing identified that would change or adversely impact the Health Board's decarbonisation objectives. The improvement actions focus on governance, workforce development, service quality and clinical safety and are not anticipated to negatively affect existing sustainability initiatives.
Welsh Language: No
There are no risks identified that would impact the Health Board's ability to comply with Welsh Language Standards or the More Than Just Words framework. The service remains committed to ensuring patients

can access care and information in their preferred language and that Welsh language needs continue to be considered within service delivery arrangements.

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

ITEMS FOR ALERT		
Issue / Risk	Action taken	Group responsible
Deteriorating UEC performance - There has been significant and sustained pressure across Urgent and Emergency Care, with associated operational and patient safety risks. Ambulance handover compliance has deteriorated from a previous position of 90–95% to 80–85%, with reported lows of 66%. Recent operational examples include high numbers of patients in the Emergency Unit, prolonged waits to be seen, overcrowding, and pressure across assessment, SDEC and short-stay footprints. Overnight waits to be seen in the emergency unit have been as high as 15 hours. There is increased volumes of attendances particularly in self-presentations leading to challenges to safely meet the demand. The current position presents risks of delayed assessment, delayed escalation, ambulance lost hours, poorer patient experience and increased pressure on staff.	A W45 / Emergency Department improvement plan has been developed in response to the deterioration in ambulance handover and wider EU performance. Operational oversight strengthened: Daily local performance review and weekly oversight with the site team are in place to monitor handover delays, waiting-to-be-seen performance and escalation actions. Ambulance handover capacity prioritised: Actions include maximising ambulance handover capacity during periods of peak demand through escalation and onboarding arrangements. Internal flow and assessment capacity under review: Work is underway to protect assessment and treatment spaces, improve internal patient flow, improve early senior clinical decision-making and accelerate discharge processes. Systematic review of concerns and incidents underway to establish degree of harm. UEC improvement alignment: The improvement plan is expected to form part of the wider UEC improvement plan, including actions to improve WTBS and delivery of the EU component of the 4-hour standard. Residual risk remains: Performance deterioration remains a live quality and safety risk until sustained improvement is demonstrated across ambulance handover, waiting-to-be-seen times, overcrowding and flow through assessment areas.	Emergency Medicine Directorate / Medicine Clinical Board / Site Team / Patient Flow and Site Services / UEC Improvement Group
Closure / de-escalation of West 2 and respiratory pathway change at UHL - Following consultation, the decision has been made to close West 2, with a managed de-escalation and formal closure underway. The change supports the Medicine Clinical Board acute model through improved acute capacity, workforce redistribution and enhanced training opportunities. Key risks remain during implementation, including reduced UHL bed capacity, delivery of respiratory and pleural pathways, retention of specialist respiratory nursing expertise, support for biopsy tracking, and potential impacts on lung cancer and pleural diagnostic services. Specific assurance is required regarding CT-guided lung biopsy aftercare and the availability of appropriately trained staff.	Following consultation, a managed de-escalation and closure of West 2 is underway, supported by Clinical Board oversight and implementation of the revised UHL ward model. Work continues to ensure safe delivery of respiratory and pleural pathways, including CT-guided lung biopsy aftercare, with ongoing review of workforce, nursing expertise, biopsy tracking and diagnostic pathway arrangements. The impact of the reduced UHL bed base is being closely monitored, particularly in relation to patient flow, admissions pressures, length of stay and winter resilience. Concerns raised by staff and clinical teams continue to be actively managed through the implementation process, supported by ongoing engagement and communications	Integrated Medicine Directorate / Medicine Clinical Board / Respiratory Clinical Team / UHL Site Team / Patient Flow and Site Services / People and Culture

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Reduced capacity is already affecting patient flow, admissions unit pressures and length of stay, with a risk of further deterioration during winter. External scrutiny, including media interest and public concern, also presents a reputational risk.	activity. While mitigations are progressing, residual clinical, workforce, operational, patient flow and reputational risks remain until pathway changes, workforce arrangements and alternative capacity are fully embedded and demonstrated to be sustainable, with progress reported through established governance arrangements.	
Interstitial Lung Disease Service: Capacity and Patient Safety Risk - The Cardiff and Vale ILD service is operating under significant capacity pressure, with material patient safety implications for people with progressive and life-limiting lung disease. Urgent new-patient waits are 26 weeks against an 8-week target, routine waits are 38 weeks, and audit data indicates that 10% of referred patients die before their first appointment. Follow-up capacity is also constrained, with reviews occurring several months beyond clinically recommended timescales. This remains a live quality and safety risk requiring executive oversight while capacity and workforce mitigations are progressed. **Impact:** • Delayed specialist assessment is affecting timely diagnosis and treatment initiation for progressive fibrotic lung disease. • The extended waits create a risk of avoidable deterioration and mortality before specialist review. • Current access performance does not meet NICE expectations for timely specialist ILD support. • Limited specialist pharmacy capacity increases medicines-safety risk and constrains treatment monitoring and optimisation. • Sustained pressure across consultant and nurse-led provision presents a workforce resilience and service sustainability risk; progress, exceptions and residual risk require continued monitoring through Clinical Board and executive governance.	A business case has been developed to secure recurrent investment in the workforce required to address the identified capacity and patient safety risks: • 1.0 WTE Specialty Grade Doctor • 1.0 WTE Band 7 ILD Clinical Nurse Specialist • 2 specialist pharmacist sessions per week The proposed investment will increase clinic capacity, strengthen multidisciplinary review and treatment monitoring, improve medicines optimisation, and enable earlier intervention and advance care planning. The business case has been approved by the Medicine Clinical Board and reviewed through the Executive Board review process. The associated vacancies are now progressing through organisational scrutiny, providing assurance that the required resource is subject to appropriate approval and governance controls. Delivery and impact will be monitored through established Clinical Board governance arrangements. **Expected Benefits and Assurance** • Improved access and reduced waiting times for new and follow-up appointments. • Earlier diagnosis and treatment initiation, reducing the risk of avoidable deterioration and supporting improved outcomes. • Stronger medicines safety, treatment monitoring and clinical governance. • Improved patient experience through timelier and coordinated specialist support. • Reduced avoidable admissions and improved workforce and service resilience. Residual risk will remain until recruitment is complete, additional capacity is operational and sustained improvement in waiting times and clinical outcomes is demonstrated.	MCB/Executive Team

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group Responsible**
NRI's The current NRI position 19 open NRI'S. Although six incidents remain overdue, there is evidence of continued progress, with four of these cases nearing completion- planning closure in October. Ongoing oversight and support are being provided to reviewers to facilitate timely progression of investigations, with regular monitoring through established governance processes to ensure appropriate management and closure of outstanding cases	A traffic-light tracker, weekly Director of Nursing oversight and direct engagement with reviewers are in place to monitor all open NRIs, address barriers and ensure timely completion, with escalation where progress is not on track.	Director of Nursing/MCB QSE Leads
Emerging theme: failure to escalate in deteriorating patients Review of recent sepsis NRIs has identified a recurring theme relating to failure to escalate clinical concerns in a timely manner. Whilst the number of cases reviewed so far is small, the consistency of this finding has prompted further review. A more detailed thematic analysis is planned to examine NRIs where escalation has been identified as a contributory factor, with the aim of understanding underlying causes, identifying opportunities for improvement and ensuring any learning is translated into practice.	**Sepsis NRI learning and thematic review:** Five sepsis-related NRIs have recently been presented at Medicine Clinical Board governance forums and at the CAV Sepsis Day in September, providing an opportunity to share learning from these cases across the organisation. In response to recommendations arising from one of these reviews, a broader thematic review of historical sepsis cases is planned. This work will examine recurring themes, recommendations and actions identified through previous investigations and assess whether agreed actions have been implemented and embedded in practice. The findings will be used to inform future improvement work and strengthen organisational learning relating to sepsis recognition, escalation and management.	Medicine Clinical Board QSE / Sepsis Group / Directorate Governance Teams

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

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Coroner's inquest learning: medication safety and acute opiate toxicity	A 3-day inquest was concluded this month concerning patient MM, where concerns had been raised regarding whether the cause of death was acute opiate toxicity. Following consideration of evidence from multiple expert and specialist sources, the coroner returned a narrative conclusion, determining the cause of death to be sepsis. No Prevention of Future Deaths report was issued. Learning identified through the inquest has been translated into service improvement work. In collaboration with the ePMA team, additional prescribing alerts are being developed to support safer opioid prescribing in older patients and those with advanced chronic kidney disease (CKD stages 4 and 5). These enhancements are currently progressing through ePMA governance processes. Further educational work is also planned, with a medical registrar involved in the case delivering teaching focused on the recognition and management of acute opiate toxicity and the wider clinical lessons arising from the inquest.	Medicine Clinical Board QSE / ePMA Team / Directorate Governance Teams

RECENT LEARNING OPPORTUNITY			
Source:	Medical Examiner reviews / Medicine Clinical Board QSE	**Reference (if applicable):**	Not applicable
What happened / what was the problem?			
Learning from recent Medical Examiner reviews has identified opportunities to strengthen how themes from mortality reviews and family feedback are translated into shared learning across the Medicine Clinical Board. Reviews continue to highlight the importance of clear communication with families, timely recognition and escalation of deterioration, robust documentation, and ensuring that learning from individual cases is visible across directorates.			
What was learned and how was this shared?			
The key learning is that Medical Examiner feedback provides an important route for identifying recurrent patient-safety and quality themes, including communication, escalation, recognition of deterioration, end-of-life care and			

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documentation. These themes are being brought through Medicine governance routes, including QSE discussion, to support reflection, identify common learning and reduce variation in practice.

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

Medicine Clinical Board is working with mortality, and Medical Examiner leads to strengthen the process for capturing and sharing learning from Medical Examiner reviews. Further work is planned to ensure themes are collated, reviewed through governance forums, and converted into clear improvement actions where required. This should improve visibility of learning from deaths, strengthen organisational learning, and support earlier identification of recurring quality and safety issues. The plan is to have a theme for the monthly QSE meeting.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Medicine has delivered a significant and sustained reduction in incidents with a status of "New", decreasing from 408 in June 2026 to 283 last month and 187 this month. This improvement reflects the commitment of clinical and managerial teams to strengthening incident management, governance and patient safety oversight.

The reduction has been achieved through weekly team-level reporting, clear accountability for Incident Managers and routine review of outstanding incidents, resulting in improved visibility and progression of cases. Additional support has also been secured from the Patient Safety Team to help sustain momentum and further strengthen performance.

While further work is required to reduce remaining backlog and achieve sustainable compliance, the trajectory demonstrates measurable improvement and assurance that patient safety risks are being identified, reviewed and acted upon more promptly, with continued oversight in place to drive further improvement.

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:	UHB Quality Committee	**Date of Meeting:**	
Representative at Clinical Board Governance:	CB QPSE Consultant Lead	**Date of Meeting:**	18.09.26

ITEMS FOR ALERT		
Issue / Risk	**Actions Taken**	**Group Responsible**
Immunology concern raised re. patients found to have follow-up not booked (FUNB) An internal review undertaken by the Immunology directorate identified 509 patients recorded as overdue for follow-up, including higher-risk cohorts within certain clinics (V50/V51 and IMMUN4 clinics). Acknowledged data quality issues, duplicate pathways and inconsistent clinic outcomes may mean the true number is lower; however, some patients had no future appointment booked. There is a risk of patients becoming lost in the system, delayed clinical review, deterioration or avoidable harm. Patient deaths (x8) noted within the identified cohort requiring mortality review, although the initial cross-check did not establish a direct correlation between delayed follow-up and cause of death.	**Ongoing:** ▪ Complete multidisciplinary mortality review of the identified deceased patients, with independent Clinical Board input, to determine whether any care or follow-up concerns contributed Full administrative and clinical validation of the Immunology FUNB cohort. ▪ Prioritise higher-risk V50/V51 and IMMUN4 patients and identify anyone requiring urgent review or expedited appointment. ▪ Cross-check clinic outcomes, duplicate pathways, appointment status and mortality information to establish the accurate cohort. ▪ Reappoint patients where follow-up remains clinically required and confirm that current patients have appropriate future appointments. ▪ Ensure Immunology patients are not automatically discharged following non-attendance without clinical review, reflecting their agreed higher-risk status. ▪ Strengthen clinic outcome recording and ongoing monitoring, with appropriate use of SOS/PIFU only following clinical assessment and clear safety-netting. ▪ Report validation findings, mortality-review outcomes and any resulting improvement actions through Directorate and Clinical Board governance arrangements.	Immunology Directorate / Clinical Immunology and Allergy Service, supported by the Specialist Services Clinical Board
Peripheral vascular cannula (PVC) documentation and care-bundle compliance	PVC LocSSIP developed for use in CC	

A recent audit carried out in Critical Care (CC) identified inconsistent completion of PVC insertion documentation, including use of insertion packs/stickers in patients subsequently transferred to CC. This aligns with Tendable audit findings. Also noted variation in maintenance records and evidence that devices are reviewed and removed promptly when no longer required. This limits assurance that insertion and ongoing care meet required standards and creates a risk of phlebitis, line-related bloodstream infection, delayed recognition of complications and potentially avoidable patient harm.	 PVC locsipp.pdf Ensure the indication, insertion details and cannulation attempts are recorded, with **twice-daily VIP scoring and maintenance checks** documented. Introduce daily review of ongoing clinical need and remove PVCs promptly when no longer required or where infection/phlebitis is suspected. Reinforce aseptic non-touch technique, hand hygiene and PVC insertion/maintenance competency through education and assessment. Current compliance; ANTT 100% all areas HH 80% C5, CCD. Haem DC 83% C4S 100% all other areas PVC 80% B4N, W8, CCD (lack of insertion sticker a factor) 86% C5H 90% Haem DC 92% c4S 93% C5 cardiothoracics 94% B1, CCU & C1 95% B4 H 100% all other areas Undertake regular care-bundle audits, provide targeted support to areas with lower compliance and re-audit to demonstrate sustained improvement. NB PVC insertion and maintenance bundles have recently been added on WNCR Agenda item for discussion at next Specialist IP&C Group to determine improvement trajectory, alongside	CC senior Nursing Teams and Practice Educators, supported by the Infection Prevention and Control Team and the Specialist Services IP&C Group. IPCG

	review of PVC-related bacteraemia investigations and share learning through IP&C governance arrangements. **Include on IPCG report for UHB noting and discussion re. insertion practice across UHB**.	
C5 Cardiothoracic Ward – Tendable audit findings: Recent audits identified variable compliance across medicines management, core standards and infection prevention. The Care Specifics inspection scored **90.4%**, with concerns including unlocked medicines storage, medicines-fridge temperature monitoring, assessment for patient-owned medicines and interruptions during medication rounds. A separate Core Standards inspection scored **93.2%**, identifying gaps relating to discharge processes, falls-risk documentation and sharps-bin management. The IPC audit scored **98.8%**, with failures concerning the indication for, and documentation of, PVC removal. Interruptions by visitors during medication rounds have increased following changes to visiting arrangements. Collectively, these findings create a risk of medication error, unsafe medicines storage, incomplete assessment or discharge documentation, avoidable falls, sharps injury and inconsistent PVC management.	Ward Sister is reviewing each failed standard through the C5 Tendable improvement process and using audit outcomes to support ongoing ward assurance. ▪ Thanks, I shared the poster with you and Dons I drafted just being translated into Welsh Feedback is still mainly positive from visitors and staff re changes Also, we are compliant with covid inquiry reaccommodation's re open visiting Concerns regarding interruptions during medication rounds have been escalated to Senior Nursing and Corporate Patient Experience teams as likely to affect all areas. ▪UHB posters drafted by Head of Patient Experience and shared for comment to advise that visitors may be asked to leave temporarily where clinical priorities, including medication or ward rounds, require this. PDF Patient Privacy and Cooperation Guidel ▪Medicines storage cupboards and fridge temperature-monitoring arrangements to be checked, with immediate corrective action where required.	C5 Ward Sister and Cardiothoracic Senior Nursing Team, supported by the Cardiothoracic Practice Educator, Pharmacy, IP&C and Corporate Patient Experience/Professional Standards teams.

	▪Reinforce protected medication-round practice and local escalation of recurrent interruptions. ▪Review and correct identified gaps in discharge, falls-risk, sharps-bin and PVC removal documentation. ▪Repeat targeted Tendable audits following completion of actions to evidence improvement and sustained compliance.	

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group Responsible**
HIW IR(ME)R visit: An announced HIW IR(ME)R inspection of UHW Cardiology is scheduled for 10–11 November 2026, with the self-assessment and supporting evidence required by 19 October 2026. A co-ordinated response to collate the required evidence of procedures and assurance across radiation governance and wider healthcare standards and responsibilities, is necessary within the required timescales.	• Radiology to lead completion and submission of the IR(ME)R documentation, working collaboratively with Cardiology and requesting outstanding evidence where gaps are identified. • Cardiothoracic DMT to coordinate preparation against wider healthcare standards and confirm named nursing, medical, cardiac physiology, quality and safety, and management leads. • Use learning from previous	Cardiothoracic Directorate Management Team / Cardiology, with Radiology as IR(ME)R documentation lead and support from Corporate Quality and Patient Safety.

	inspections and the shared draft inspection report to review employer's procedures, including alignment with practice, formal ratification and clear communication to relevant staff. • Complete the self-assessment, collate supporting evidence, close identified gaps and maintain oversight of readiness ahead of submission by 19 October and inspection on 10–11 November 2026.	
Nephrology &Transplant (N&T) dialysis contract tender process N&T are currently going through a tender process for the dialysis contract for the next 10 years, which is due to expire in July 2027. B Braun, one of the companies informed N&T that they were intending to issue a break clause within their leases of three units which would have meant that from March 2027 access to those facilities would have been lost and would have affected over 260 patients.	Issue has been resolved with Cardiff & Vale UHB becoming direct holders of the leases for those buildings whilst work continues on the tender process to ensure timely delivery.	N&T DMT
Welsh Kidney Network (WKN) Deep Dive 2026/2027 Chronic kidney disease prevalence in Wales has increased by 33% over the last 12 years, with demand continuing to rise across dialysis, transplantation and supportive care pathways. Current commissioning, contractual, funding and activity-reporting arrangements are inconsistent, limiting transparency, performance benchmarking and assurance on quality, equity and value for money.	**Committee Actions endorsed** • Implement standardised all-Wales commissioning arrangements, reporting schedules,	WKN NHS Wales Joint Commissioning Committee (JCC) Nephrology & Transplant Directorate

Without stronger commissioning controls and pathway optimisation, there is a risk of escalating service and financial pressures, continued reliance on unit-based dialysis, increasing transplant waiting lists and variation in patient access and outcomes.	minimum datasets and formal change-control processes. • Introduce annual open-book financial reviews, rebase commissioning currencies and review non-commissioned activity to improve financial transparency and assurance. • Establish a consistent governance framework for commercial dialysis contracts, including tri-partite accountability, risk-sharing and contract management arrangements. • Progress pathway improvement programmes focused on prevention, early intervention, medicines optimisation, transplantation and delivery of the 30% home dialysis ambition by 2029. • Improve data quality, including equality information, to enable monitoring of access, outcomes and health inequalities. • Develop implementation plans for 2027/28, with clear oversight,	

	milestones and outcome measures through the Welsh Kidney Network and Joint Commissioning Committee	

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Use of wheelchair accessories and Orthosis for restraint purposes.	ALAS has been working closely with the Mental Capacity and Consent Team within Cardiff and vale Safeguarding, as well as Legal and Risk, in relation to advice regarding Deprivation of Liberty Safeguards (DoLS) and the use of restrictive interventions, such as wheelchair harnesses and orthoses, where these are required to maintain an individual's safety and wellbeing but may restrict their physical liberty. More recently, there has been an increase in referrals relating to restrictive interventions for behavioural concerns. This is thought to be aligned with autism spectrum diagnosis (ASD) diagnosis. The ALAS team are running a report of referrals to validate. There can be reluctance from community clinicians to complete the associated risk assessments, which can result in ALAS clinicians having difficult conversations regarding clinical responsibility, decision-making, and the completion and documentation of risk assessments.	ALAS / Legal and Risk / Safeguarding

	ALAS are currently reviewing and updating our processes and guidance in this area and will continue to work with Safeguarding colleagues and Legal and Risk as further advice and clarity become available.	

RECENT LEARNING OPPORTUNITY			
Source:	Danielle James (ALAS	**Reference (if applicable):**	Review of sustainability and reconditioning work

What happened / what was the problem?

An internal review identified that new equipment and replacement parts were being purchased while some existing equipment and components were being scrapped. Analysis of frequently used parts, including issues, repairs and associated costs, identified an opportunity to safely recondition suitable components and return them to stock.

What was learned and how was this shared?

The review highlighted that potentially reusable items were being sent to landfill and replaced with new components. Initial assessment indicated that this was neither environmentally sustainable nor cost-effective. The work also demonstrated the importance of a multidisciplinary approach, involving technical, clinical, specialist seating, Q&I and stock teams to ensure that appropriate expertise informs the reconditioning policy and processes.

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

A formal reconditioning policy is being developed, alongside recruitment to two dedicated reconditioning posts. The project will continue to be evaluated to assess its impact on sustainability, stock utilisation, waste reduction and cost effectiveness.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

•Ward B1 Cardiology celebrated World Heart Day 29th September. They were sharing information about heart health and inviting patients to contribute to their 'Every Heart Has a Story' bunting.

Patients wrote short notes about their experience of care on the ward, including:

♡ "Many thanks. You do more good than you know xxx"

♡ "Respect. Just to say thanks for the excellent care, kindness and support I have had here. I'm truly grateful. Thank you x"

♡ "Lots of love and help always. Started my journey from GP to Llandough. Great care from those in the ambulance right through to Ward B1 North, and excellent care and positivity from staff throughout." 👏



●Letter sent to CEO and Executive Medical Director on 29 th September from NHSBT recognising the Organ Retrieval Team and commending x2 practitioners that have actively sustained the work of organ retrieval and transplantation travelling significant distances and working long hours for a period of 5 years or more. They were congratulated and the significant challenges of recruitment and retention in the UK service acknowledged.

● E-mail to CEO 23rd September complimenting the Haemophilia team

FAO Chief Executive

I feel I must share with you the highly professional and exceptional service we have experienced at The Heath today.

*My son ***** arrived in Cardiff today to start at university here - he has haemophilia and his team at Bristol had informed the team at The Heath he would be living in Cardiff.*

Jack received a phone call from one of the CNS Gayle - inviting him to clinic to meet the team - could we come now we asked? Yes! So we attended the unit where we were met by Gayle and Dr Tessa. A prompt and thorough assessment including some routine bloods - as well as loads of information and reassurance. As a mum leaving her (precious !!) son at university I feel hugely reassured that if he needed any medical intervention from the team then he would be very well cared for.

I cannot thank the team enough for taking the time today to meet with us.

Please share my thanks to the team.

Best wishes from a grateful mum.

●The Thoracic Team hosted a highly successful Thoracic educational Day for nurses and AHPs from across x3 health boards.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS				
Case No	**Action**	**Due Date**	**Reason for Non Delivery**	**Risk (RAG)**
ID 45048	**Implement the Welsh Clinical Portal custom results dashboard**, including the ability to sort by the most recently	NRI Closed 30/09/25	Delivery is dependent on **Digital Health and Care Wales (DHCW)**. Although development and a June/July demonstration had	**Red**

Shared NRI (UHB & PHW) Closed 30/09/25	reported or amended microbiology/mycology result. **BACKGROUND- delayed identification and action on significant mycology results:** Following stem-cell transplantation, x3 urine samples taken between May and July 2023 identified *Cryptococcus neoformans*. The confirmatory results were added retrospectively to the original sample reports and were not clearly flagged or brought to the top of the Welsh Clinical Portal. There was no reliable process within Haematology for tracking pending microbiology/mycology results, and the Public Health Wales escalation procedure did not mandate direct notification of this significant finding. The results were therefore not reviewed or acted upon, delaying diagnosis and treatment. The Coroner concluded that the delay contributed to the patient becoming acutely unwell and that earlier recognition would have enabled earlier treatment to be considered; Mr Thomas was unlikely to have died when he did. The ongoing system risk is that significant or supplementary microbiology results may remain unseen where they are added to historical reports without an effective alert, creating the potential for delayed treatment and avoidable harm. No Prevention of Future Death report was issued to the Health Board, but the national digital solution remains outstanding. Haematology actions all completed as per Improvement Plan.	Inquest 16/09/25	been anticipated, the September 2026 update could not confirm whether the dashboard would be included in WCP release 26.2. This is a national system change requiring development, testing, approval and release scheduling. A DHCW representative attended a Haematology Directorate QSE meeting earlier this year to demonstrate the planned WCP upgrade which would allow filtering of results by report date (rather than sample date as at present). It was agreed that this would be a significant improvement. Confirmation of this planned upgrade as well as timeframes has been requested again.	

NEW / CLOSED / AMENDED RISKS

CLINICAL BOARD QUALITY UPDATE REPORT			
Governance Group:	Quality Committee	**Date of Meeting:**	27th October
Representative at Clinical Board Governance:	PCIC Clinical Board Quality, Safety & Experience Group	**Date of Meeting:**	22nd September 2026

ITEMS FOR ALERT		
Issue / Risk	Actions Taken	Group Responsible
Risk ID: Primary, Community & Intermediate Care/2026-27/02 HMP Cardiff Healthcare Service Capacity and Sustainability **RR 20** There is a risk that safe, sustainable and continuous primary healthcare provision at HMP Cardiff cannot be maintained following notice given by the Clinical Director and the GP practice to terminate the current Service Level Agreement. Without a timely and viable replacement service model, this may result in reduced clinical leadership and GP capacity, disruption to continuity of care, delays in assessment, diagnosis and treatment, unmet physical and mental health needs, and regulatory non-compliance. In addition, limited or delayed access to secondary and acute mental health services may compromise the timely assessment and management of individuals with complex mental health needs, increasing the risk of clinical deterioration, self-harm, suicide, safeguarding concerns, emergency hospital admissions and avoidable harm within a highly vulnerable custodial population. National Reportable Incidents and near-miss incidents reported at HMP Cardiff in recent months, predominantly relating to mental health provision, are being investigated through the standard Patient Safety Learning review process. Emerging themes are being reviewed to identify contributory factors, inform service improvements and strengthen patient safety arrangements. These findings will also inform ongoing workforce, service and mental health provision reviews.	Executive oversight is in place, and an Interim Senior Nurse for Mental Health in HMP has commenced. A joint improvement plan is being implemented across both Clinical Boards, supported by regular oversight and monitoring. Weekly updates are provided to the interim Senior Nurse regarding psychiatry cover and associated contingency arrangements. Work is progressing to resolve MDT scheduling challenges, with both Clinical Boards actively seeking a practical solution. In addition, both Clinical Boards have committed to attending future Prison Partnership Meetings to present waiting time and performance data, providing greater transparency and assurance regarding service improvement. Learning from Patient Safety Learning Reviews are being used to inform service improvement actions, workforce planning and the ongoing review of healthcare and mental health provision within the prison. Further	PCIC & Mental Health Clinical Board

	recommendations will be incorporated into governance and quality improvement plans as reviews are concluded.	
Risk ID: Integrated Community Care Services (ICCS)/2026-27/03 District Nursing Workforce Capacity Deficit Resulting from Registered Nurse Vacancies **RR 20** There is a risk that District Nursing cannot deliver timely, preventative community care due to 23% registered nurse vacancies and sickness absence, resulting in delayed care, increased deterioration, avoidable hospital admission and patient harm.	Daily call prioritisation and cross-team staff redeployment continue to mitigate operational risks and maintain patient safety. Monitoring of key quality indicators is in place. Recruitment has been strengthened through the student streamlining programme and streamliners are currently being onboarded, which will, in due course support workforce resilience and service sustainability. Further recruitment from an internal recruitment advert is being progressed.	PCIC CB & UHB/Corporate Nursing for Nurse Recruitment Strategy

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Escalating backlog of Continuing Health Care (CHC) case reviews within the adult and Older Persons Mental Health (OPMH) cohort. This includes, CHC and Funded Nursing Care (FNC) follow up reviews and the CHC. From a 1500+ caseload, 45% breached assessment review date in September. Appeals and Retrospective Claims Position is also backlogged with 48 cases activated awaiting review with a further 22 received = 70 pending. **Turnaround actions;** Ask to release nurse assessor staff from the Adult/OPMH CHC pathway to support other complex care speciality work to support rightsizing packages of care for patient quality and safety and to release financial benefits would impact negatively on nurse assessor capacity to take meaningful action to address the backlog.	Recruitment to vacant posts is actively progressing to strengthen capacity and support a sustainable reduction in the review backlog. Two locality teams are being co-located to improve operational resilience, facilitate flexible deployment and maintain service cover. The Optimising Complex Care programme and associated workstreams are progressing to standardise practice, strengthen governance and support a consistent approach to Complex Care across Clinical Boards. A cross-Clinical Board Quality Impact	Turnaround Board Optimising Complex Care Programme

	Assessment approach is being applied to proposed turnaround expectations, with Executive Nurse Director oversight to ensure that risks, benefits and potential unintended consequences are assessed and appropriately managed.	
Proposed community bed changes at St David's Hospital present a system risk. Expected flow improvements from the optimising flow programme have not to date been achieved; length of stay remains high and capacity constrained. **Turnaround actions:** The bed closures as part of the optimising flow programme is designed to financially support delivery of integrated end of life care strategy in the form of a social contract the UHB has with MacMillan.	Immediate escalation actions are in place to address the current BCI position, with progress monitored through established governance arrangements. Joint workshops with Medicine and stakeholder Clinical Boards are progressing to agree acute frailty pathways, responsibilities and delivery arrangements. Wider stakeholder engagement is underway to inform implementation and identify operational risks and dependencies. Delivery of the Optimising Flow Strategy is subject to ongoing oversight, with recurrent benefits, system sustainability and quality impacts monitored through the Quality Impact Assessment. Organisational change consultation will proceed through established governance, informed by completed Quality and Equality Impact Assessments, with identified risks and mitigations monitored.	PCIC Clinical Board with Medicine Clinical Board
High-risk cohort (0.5% of the population) – the Health Board is not currently commissioning this Directed Supplementary Service (DSS) because no funding has been identified. The Primary Medical Services (People Living with Severe Frailty in Their Own Homes) (Wales) Directions 2025 and	PCIC is actively supporting the UHB Community by Design programme. PCIC is exploring all available funding options	Community by Design

associated specification is to redirect Welsh Government funding to primary and community care. The scheme aims to identify people aged over 65 who are living with severe frailty. The scheme supports optimised treatment and care, reduces the risk of hospital admission and enables ongoing monitoring. **Community by Design Expectations (CbD);** The Cabinet Minister has stated it is a priority for Health Boards to increase their spending on primary and community care by 0.5% each year from 2027-28, with an urgent expectation to agree which services make up the baseline for measuring the increase against and identify which services and workforce will shift to support this objective. Health Board plans for this increase are required by the end of October.	and has escalated the funding gap for Executive review, including consideration of redirecting resources to commission the service through GP practices. Progress will be monitored through established programme governance arrangements.	
Primary, Community & Intermediate Care/2026-27/04 Complex Care Placement Failure (Patient ..) RR 20 There is a significant risk to the Health Board's ability to discharge its statutory responsibilities as Commissioner of Care for an individual following the breakdown of a highly complex community placement. The placement has served notice to terminate the current placement due to the intensity of care required, staff burnout, and ongoing safeguarding and clinical concerns.	Executive oversight is in place, with a multi-agency approach being coordinated to explore all available options, mitigate immediate risks and identify a safe and sustainable long-term solution. The situation remains high risk and requires ongoing executive monitoring and support.	PCIC Clinical Board
DOSH/2025-2604 Loss of automated results management **RR 20** Ongoing absence of automated results management in the Department of Sexual Health following the liquidation of Millcare EPR in 2025. Agreement secured to integrate LIMS2 with Lillie Healthcare as a long-term solution, but UHB are reliant on DHCW to prioritise and deliver a replacement system interface.	Ongoing engagement with UHB Digital and Digital Health and Care Wales (DHCW) is in place to establish a timeline for resolution and implementation of required actions. Progress is being monitored through established governance arrangements to minimise operational impact and support risk mitigation.	CAV Digital & Health Intelligence & PCIC CB

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Rapid Assessments tools completed for		
Audit plans; Integrated Discharge Service – Audit of UHB Discharge Procedure	Audit is in progress	Primary Care Quality & Safety

Use of CIVICA scheduling and PARIS (Digital patient record) to work up capacity and demand in District Nursing and other Community Nursing teams	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
2026/27 Flu vaccination	Winter campaign is progressing to protect staff, patients and services. There are walk-in clinics with dates and locations across CAVUHB.	Health Protection and Immunisation Business Unit and PCIC CB with PHW support
Lansdowne Ward at St Davids	Independent peer review, enhanced audit programme and staff feedback work progressing to address concerns raised through Llais and by families. Improvement actions will be implemented and evaluated to provide stronger assurance on progress, impact and outcomes.	PCIC Clinical Board

RECENT LEARNING OPPORTUNITY

Source:	Improvement Story - Work with GP practices on the eight diabetes care processes	**Reference (if applicable):**	

What happened / what was the problem?

Fifteen practices who were not consistently achieving compliance with monitoring of all 8 diabetes care processes. They received multidisciplinary support using data from the Primary Care Information Portal.

The project aimed to demonstrate that delivering gold-standard, person-centred diabetic care would improve treatment target achievement and clinical outcomes.

What was learned and how was this shared?

Common issues included inconsistent understanding of the care processes, variable recall systems, incomplete searches, coding and template issues, access for housebound patients, non-attendance and language barriers. Practices received support on recall and follow-up arrangements, coding, templates and learning from higher-performing practices.

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

Follow-up data showed improvement across most participating practices. Attendees noted that recording all eight processes was an essential first step in identifying gaps and improving treatment targets. The importance of equitable access for housebound patients and populations experiencing deprivation or communication barriers was emphasised. Further visits are planned for the practices subsequently identified as performing less well against the standards and care processes.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Inaugural PCIC Infection Prevention Control Group meeting held on 7th October and will be bimonthly

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

NEW / CLOSED / AMENDED RISKS

PCIC is undertaking a programme of risk register deep dives with Business Units to strengthen assurance and ensure that risks are being assessed, scored and escalated appropriately corporately.

CLINICAL BOARD QUALITY UPDATE REPORT			
Governance Group:	Quality Committee	**Date of Meeting:**	22 October 2026
Representative at Clinical Board Governance:	Director of Nursing/Multi-Professional Teams	**Date of Meeting:**	

ITEMS FOR ALERT		
Issue / Risk	**Actions Taken**	**Group Responsible**
Transfusion laboratory workforce capacity and resilience The All-Wales Transfusion Laboratory Workforce Capacity and Resilience Review, (commissioned by the Welsh Blood Service (WBS) on behalf of the Infected Blood Inquiry (IBI) Next Steps Oversight Group) identifies that the local service is under-established in a number of areas. This creates a potential risk to service resilience, statutory and regulatory compliance, and the ability to maintain a safe and sustainable transfusion laboratory service. The review does not describe a failing service, but it identifies a service operating with insufficient resilience and narrow safety margins.The review provides a clear case for targeted workforce investment and structural redesign rather than simply increasing establishment. Immediate priority should be given to protecting senior transfusion capacity, stabilising Haemoglobinopathy and other specialist services, strengthening transfusion practitioner capacity, and ensuring LIMS implementation does not further compromise operational or governance resilience.	The local report has been shared and the team is identifying priority actions to address the local findings. The position will be included in the Clinical Board Executive Review process and progress monitored through clinical board QSE and regulatory compliance meetings	Laboratory Medicine & Blood Transfusion Quality meeting/ Clinical Board Executive Review / QSE Sub-Committee
Mortuary HTA incidents One incident reported to the Human Tissue Authority on 7 October 2026 as HTARI. Incident related to the retention of a whole kidney that was not documented on the post-mortem worksheet in accordance with the agreed process. The specimen container was labelled other postmortem tissue when it should have been labelled as kidney, consent until the case has concluded was given and case remains open. Incident requires detailed review to identify where controls and documentation processes were not followed.	Incident reported promptly to the HTA. Root cause analysis and corrective and preventative action plan (CAPA) are being developed. Quarterly audits of wet tissue and PACE holdings are conducted, and no similar issues have been identified, as part of those audits or as part of working practices. There are some limitations to the audit in that only worksheets and specimen container labels are checked rather than opening containers, a proportionate approach as part of CAPA will be identified. Findings, wider	HTA Compliance Group

	learning, emerging risks and actions will be reviewed through the HTA Compliance Group and Clinical Board quality and safety governance routes.	
NOVA blood ketone test strips National supply disruption and product recall caused a major shortage. Potential to run out of strips without intervention, risk that DKA is not identified and managed appropriately. Existing supplies of test strips are being redistributed to ensure they are available for highest priority clinical situations coordinated by pharmacy and point of care testing colleagues Supply of NOVA strips not expected to return to normal until new year, alternate meters being arranged	Patient safety notice shared with interim guidance to preserve remaining supply and prioritise use in patients with most significant clinical need. To help conserve POCT ketone test strip stock the ketone quality control requirement has temporarily been reduced. As a temporary contingency, POCT will issue **Menarini GlucoMen Areo GK meters** to locations that currently undertake POCT ketone testing. Although the GlucoMen Areo GK can perform both glucose and ketone testing, **it will be used for ketone testing only** during this period, until acceptable Nova ketone test strip supplies become available. **These meters are not suitable for Neonatal use, thus Nova stock will be protected and managed via Pharmacy for these areas, if needed.** POCT team have reviewed testing activity on the connected Nova StatStrip glucose/ketone meters and identified the locations that will require a replacement, roll out of different meters and strips (starting with highest need areas) commenced 20th October.	QSE sub-committee

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Laboratory Information Management System implementation Laboratory Medicine identified significant outstanding issues ahead of the planned Blood Sciences LIMS go-live on 16 November 2026. These include aliquoting, electronic test requesting and the potential effect of delays on other health boards.	System updates are being designed and implemented, and the risks continue to be managed through Laboratory Medicine and LIMS programme governance. Further meetings arranged to discuss feasibility of go live date	LIMS Programme Board / Laboratory Medicine / Regulatory compliance group
Clinical Board governance audit The final Internal Audit report on CD&T governance arrangements has been issued and will be presented to the Audit and Assurance Committee in November 2026. Reasonable assurance concluded.	Three agreed recommendations and associated actions have been uploaded to AMaT. Review terms of reference for governance groups, review quoracy arrangements and continue to develop further recurrent savings schemes. The identified action leads are required to provide progress updates and supporting evidence through the system, enabling formal assurance reporting to the Audit and Assurance Committee.	Clinical Board Senior Management Team / Corporate Governance / Audit and Assurance Committee
Concerns and communication themes Concerns continue to reflect difficulties cancelling and arranging appointments, waiting times and communication. Recent cases include patients reporting that they did not receive appointment correspondence and were subsequently removed from waiting lists or experienced further delay.	Individual cases are being investigated through the Listening to People process. Booking teams are contacting affected patients and services are reviewing available evidence regarding appointment communication.	QSE Sub-Committee

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Fuller Inquiry and Ockenden recommendations Continued assurance is required regarding implementation of the Fuller Inquiry recommendations and the recommendations relating to maternal, fetal and perinatal care after death.	Substantial progress has been demonstrated against the Fuller recommendations. The non-conforming temporary body-storage unit has been withdrawn from use. Installation of additional	HTA Compliance Group / QSE Sub-Committee

	CCTV and TDSI swipe-in/swipe-out controls is planned for the end of October, and a compliant winter-capacity plan is progressing through procurement and finance. Public Health Wales is considering inclusion of the security and dignity of deceased people within updated All-Wales safeguarding training; an interim staff briefing is also being developed. The fetal pathology review has identified established controls, with further work progressing to evidence full HTA-aligned practice and audit arrangements.	
National Reportable Incident closure One complex Radiology National Reportable Incident investigation has completed the required review and approval process. 3 NRI's remain under investigation, with closure dates in November and December	The Patient Safety Learning Review and improvement plan received Executive sign-off and were uploaded to Datix to enable closure. IO's working with patient safety colleagues to progress learning reviews	QSE Sub-Committee
LSW Lift update Access to 1st floor LSW to access outpatient physiotherapy has been challenging due to lack of working lift that side of the building, necessitating patients to walk the other side of the building to access lift and walk through ward area to get to physio. A working group has been set up with key stakeholders and estates	A complete new system has been ordered and should arrive within 11 weeks which should rectify the situation. In meantime a risk assessment has been completed and signage to alternative access improved, where possible patients are triaged to access alternative outpatient physio where using the stairs or accessing via alternative route may be more challenging	Health and safety group

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Cellular Pathology has strengthened cancer tracking and prioritisation following review of National Reportable Incidents.
Clinical Coding has reported improved engagement with clinical teams, including vascular surgery, cardiac surgery and stroke services. Operational changes to focus on coding episodes within one month of discharge have contributed to a marked improvement in performance since April 2026. The local Clinical Coding Policy and improvement plan are also being aligned with national strategic objectives.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)
47616	A defined pathway for follow up and surveillance of patients with ERCP stents should be developed with Radiology and referring specialities	January 2025	Work has progressed but due to number of stakeholders involved agreement with final version of SOP has taken time. Further meeting planned with stakeholders to move forward	Amber

NEW / CLOSED / AMENDED RISKS

- A new or amended workforce resilience risk should be considered for Blood Transfusion following the All-Wales Transfusion Laboratory Workforce Capacity and Resilience Review and the identification of under-established areas.
- The Clinical Board governance audit actions have been transferred to AMaT for formal monitoring and assurance.

CLINICAL BOARD QUALITY UPDATE REPORT			
Governance Group:	C&W CB QS&PE meeting	**Date of Meeting:**	22nd September 2026
Representative at Clinical Board Governance:	CB, O&G, ACH, CYPFHS	**Date of Meeting:**	

ITEMS FOR ALERT		
Issue / Risk	**Actions Taken**	**Group Responsible**
transfer of budget for CHC –LD from PCIC to C&W Risk is that the care packages are not being regularly reviewed and monitored by Swansea Bay UHB due to capacity which may result in unnecessary financial impact for CAVUHB and potential clinical risk to patients.	£39M transferred over and increased our control over spend by £5.3M. Line of sight to 1.5M saving if POC reviewed. QIA completed. SBAR to support additional resource for review of existing packages to go to VBSG for approval. Exec to Exec conversations with Swansea Bay UHB ongoing regarding responsibility and resource. Following discussions with PWC, work ongoing across the UHB to release CHC assessing staff and registered LD nurses working within the UHB to support focused review of cases.	C&W LD team are reviewing the top 40 cases. Need workforce to undertake the reviews and reduced packages. Discussed at turnaround meetings.
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. Both cases being transferred over to registered nursing agency provision.	CYPFHS Directorate Management Team
Adult Learning Disability (CHC) Governance Arrangements	Concerns regarding off-framework placements. Inability to obtain assurance around safety, quality and value of care provided due to main service responsibility sitting with Swansea Bay UHB. RIF Funding slippage money to be used this financial year on procurement of Tricordent support, with expectation of a governance and oversight framework delivery.	Director of Nursing & CYPFHS Directorate working through list of adult LD packages of care and seeking reviews. Continuing to link with JCC where placements are via CCAPs framework. Will ensure part of the UHB's new complex care board.
Potential loss of BSGE Accreditation (Endometriosis Service). This will result in increased waiting times for women with DIE (deep infiltrating Endometriosis) neighbouring	Accreditation ends in December 2026. Options discussed with Executive Team at Executive Performance Review and Turnaround Meetings.	Executive Team to take to next UHB Board for decision on continuing without accreditation

accredited services are unable to absorb these women so likely referrals to England will be required. The service will cease without accreditation The harm to women is prolonged experiences of debilitating pain which is life limiting	Gynaecology Service Summit has taken place to work on mitigation actions and to further explore regional joint working opportunities.	C&W Clinical Board Senior Team/Gynae Senior Team & Execs

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group responsible**
Outcome of current BR+ assessment received. Service is currently not compliant with Band 7 workforce.	Consideration of assessment and risk being reviewed.	O&G DMT/Clinical Board
Ongoing HV JD review	Move via UNITE to move HV's in C&V to a collective Grievance stage	Executive Director for People & Culture overseeing an all-Wales draft HV JD suite has been out to CYPFHS for comment, but no further update received to date.
Plan for ND delivery plan has gone to UHB Finance Group for ratification	Approval from COO w/c 31/8 to progress with hybrid outsourcing & agency psych capacity plan to reduce 3 year waits to end of year.	Directorate to enact.
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. SBAR has been written and linking with ECOD to finalise before going to NMB for approval	CYPFHS Directorate Management Team - SOP being finalised and will need ratification Director of Nursing / ECOD
Potential of 3 children from Gaza to be sent to CHFW in October for treatment. Details unknown at this time.	Awaiting further information	CHFW DMT/Clinical Board

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group responsible**
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.	Clinical Board & Directorate Management Teams – weekly CB Datix review meeting established
ePMA Rollout and DALs	Successful rollout across Gynaecology and Children's Hospital. Incomplete DALs issues being managed at ward level. Prep and comms regarding implementation of the	ePMA team producing comms plan and supporting materials which will be shared.

	requirement for DALs to be fully completed and signed off prior to discharge underway.	

RECENT LEARNING OPPORTUNITY			
Source:		**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

Children's Rights Forum has been re-established with positive engagement of stakeholders.

Work between the Clinical Board and Corporate IP&C Team on reducing C Difficile rates has been submitted for NHS Improvement Award.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

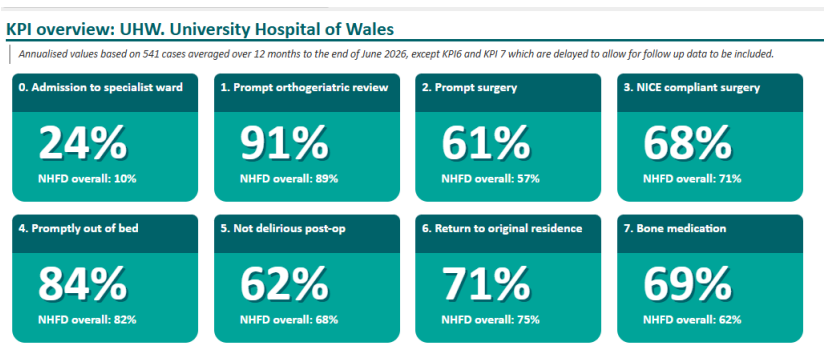
Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)
	X1 overdue NRI:			
114158	PSLR finalised. Awaiting factual accuracy to be completed. Closure meeting being arranged to progress to closure following factual accuracy completion.	September 2026	PSLR report being finalised.	

NEW / CLOSED / AMENDED RISKS

Further high scoring risk (20) reduced to 8 following WG confirmation of ongoing funding in principle.

Governance Group:	Clinical Board QSE	**Date of Meeting:**	Executive Quality and Safety Committee
Representative at Clinical Board Governance:	Director of Nursing	**Date of Meeting:**	October 2026

ITEMS FOR ALERT		
Issue / Risk	**Actions Taken**	**Group Responsible**
Incomplete ePMA Discharge Advice Letters	**Current position and action taken** The October update recorded 279 incomplete discharge advice letters (DALs) across the Surgery Clinical Board as of 30 September 2026. The largest specialty backlogs were General Surgery (128), Trauma and Orthopaedics (81), and Orthopaedic Spinal (28). As these letters have not completed the mandated complete-and-send process, they remain subject to directorate recovery action. **Review and oversight** A dedicated member of staff has reviewed the DALs identified as outstanding across the Surgical Clinical Board during the past four weeks, and this review is nearing completion. This provides a clearer understanding of the backlog and supports targeted follow-up by the relevant directorates. **Additional assurance identified** Approximately 50% of patients with an outstanding DAL have a clinic attendance letter on file recording the relevant admission dates, diagnosis, and follow-up plan. Although this does not remove the requirement to address incomplete DALs, it provides evidence that key clinical information has been communicated for a substantial proportion of affected patients. **Actions to strengthen assurance** • Complete the review of outstanding DALs and provide directorates with targeted recovery information. • Continue directorate recovery action for every DAL that has not completed the mandated complete-and-send process. • Identify clinic attendance letters separately within performance reporting to show where key clinical information has already been communicated. • Agree and document whether clinic attendance letters containing the required elements of a discharge summary can be recognised as equivalent communication for this reporting exercise. • Maintain oversight through regular governance reporting until the residual backlog has been resolved.	Surgery Clinical Board; Surgical Directorates; ward and specialty teams
Infection prevention surveillance: E. coli and MRSA	**Current position** The September Executive Review reported 13 E. coli cases against a target of 5—eight above the reduction expectation and 117% higher than in the equivalent period last year. Two MRSA cases were reported against a target of zero. **Work undertaken and current controls** • Root cause analysis investigations are under way.	Surgery Clinical Board; IPC; relevant ward and directorate teams

ITEMS FOR ALERT		
Issue / Risk	**Actions Taken**	**Group Responsible**
	• Catheter care and Visual Infusion Phlebitis (VIP) monitoring remain areas of focus. • Peer audits and core infection prevention and control audits are being undertaken. • Ward improvement plans are in place to address identified concerns. **Improvement and oversight** Lead nurses are taking forward a dedicated improvement workstream. Progress and impact will continue to be monitored through infection-prevention and Clinical Board governance arrangements, with further action taken in response to investigation findings, audit results, and surveillance trends.	
NHFD mortality statistical alert	**Current position and review** NHFD mortality is currently above the 2 SD threshold however our KPIs are above or on a par with the rest of the UK however the health board appears to be an outlier in relation to inpatient falls resulting in a hip fracture  **Existing assurance and scrutiny** A focused review by the Clinical Board director is examining inpatient falls and ASA classification to ensure they are accurate Four of the 12 deaths within 30 days during Q1 2026 involved patients who had fallen while in hospital. All 12 deaths have already been through and M&M mortality review. The has been not themes raised through this process or via a medical Examiner process No ward-level indicators of concern have been identified. The position has therefore been identified, escalated, and considered by senior clinicians, with clear areas for further investigation. **Proposed strengthened governance** A dedicated multidisciplinary hip-fracture task force has been agreed to provide focused recovery oversight. **Monitoring and next steps** The task force would meet fortnightly to review every hip-fracture	Trauma and Orthopaedics; Surgery Clinical Board

ITEMS FOR ALERT		
Issue / Risk	**Actions Taken**	**Group Responsible**
	case, monitor the full KPI set, examine mortality during each reporting period and identify actions arising from the findings. Membership is being discussed with progress, actions and evidence of impact reported through the established Trauma and Orthopaedics and Surgery Clinical Board governance routes.	
Breast Validation	**Current position** Previous mammography surveillance arrangements, including referrals upgraded from urgent or routine to urgent suspected cancer, were predominantly manual and paper based. The process relied heavily on individual staff members and lacked resilience during periods of absence. Rapid reviews identified missed or delayed follow-up and showed that patients could fall outside the intended surveillance pathway. **Immediate actions taken** • **Digital surveillance:** Paper-based arrangements have been discontinued, and all patients have been transferred to a database that enables more reliable tracking. • **Management oversight:** A strengthened structure is now in place, led by a General Manager and Directorate Manager. A Service Manager is due to join next month. **Actions under way** • Complete clinical harm reviews, pathway validation, and incident assessments, including consideration of duty of candour and redress. - aim to complete the validation of 3200 surveillance patients by the end of October • Maintain multidisciplinary team oversight and reconcile historic records with the new surveillance database. • Validate urgent and routine lists, supported by tracking, referral-to-treatment oversight, and standard controls. • Arrange an independent multidisciplinary fact-finding review in line with the normal Patient Safety learning review arrangements • Complete the formal governance review, preserve relevant records, and investigate digital interfaces. • Assess capacity requirements and develop a contingency recovery plan alongside validation activity. **Executive oversight** Progress on validation is reported weekly to the Executive Quality and Safety Committee.	SCB Triumvirate team and QSE structure

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Complaint demand is concentrated in treatment, assessment, and appointments Recurring access, cancellation recovery and communication themes	**Current position and oversight** 135 open complaints for the period April to 22 August. Analysis of 470 coded subjects provides a clear understanding of the principal drivers: 181 concerned clinical treatment or assessment and 147 concerned appointments, together representing 70% of coded subjects. Communication was the next-largest theme, with 49 coded subjects. This analysis enables improvement activity to be targeted towards access, pathway management and proactive communication. **Timeliness and existing controls** Surgical Services closed 123 of 156 complaints within the required timeframe, achieving 78.8% timeliness. The improvement approach is focused on early resolution through clinical teams, a named point of contact within each area, and direct clinician correspondence to patients copied to their GPs. These arrangements support clearer ownership, earlier clinical input and improved continuity of communication. **Targeted improvement priorities** The September review identified recurring themes involving delays in surgery, appointments, diagnostics, results and follow-up; slow rescheduling after cancellation; limited updates; and difficulty contacting teams. **Assurance and next steps** . Existing controls promote early resolution, named accountability and proactive communication. Continued assurance will be provided through monitoring of complaint volumes, response timeliness, recurring themes and evidence that actions are reducing delays, improving cancellation recovery and strengthening communication. Higher-potential-harm concerns should continue to receive prompt clinical review and escalation through established Patient Experience, Concerns and Clinical Board governance arrangements.	Surgery Clinical Board; Surgical Directorates; Patient Experience and Concerns teams
Risk-register oversight	The Executive Review reported 239 risks, with moderation required for two directorates. Weekly risk meetings were in the diary for emerging risks and QSE issues.	Surgery Clinical Board; Directorate QSE groups
National audit data gap	The Executive Review reported that the Health Board was not collecting pelvic-fracture data, and that identification of patients requires a Health Board-wide approach because only a proportion attend through trauma.	Surgery Clinical Board; relevant Clinical Boards; Clinical Effectiveness

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Patient experience remains above benchmark	For April to August 2026, both reported patient-experience measures remained above the 85% benchmark in every month. In August, approximately 97% reported feeling safe and approximately 90% reported a positive overall experience.	Surgery Clinical Board; Patient Experience
Positive IPC performance in several standards	Tendable data was described as generally positive across nursing teams, with robust performance in ANTT, linen management and several equipment and environmental standards. Targeted work continues for cleanliness, hand hygiene, Bare Below the Elbow and peripheral vascular cannula compliance, with repeat and peer audit planned.	Ward Sisters and Charge Nurses; IPC; Surgery Clinical Board

NOT APPLICABLE

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

What happened

DF2 Bracing — Patient Improvement Pathway

Following a concern the Surgery Clinical Board has introduced DF2® bracing for children with femoral fractures following major trauma. This pathway replaces elements of the traditional hip-spica approach with a less invasive treatment option designed to maintain fracture stability while improving comfort, recovery and the experience of care for children and families.

What was learned and how was this shared

Expected patient benefits

- Maintains fracture fixation while allowing the surgeon to adjust hip flexion, extension, adduction and abduction as clinically required.
- May reduce or avoid the need for theatre treatment and anaesthesia.
- Could reduce inpatient stay from approximately ten days to one day, enabling earlier recovery at home.
- May reduce avoidable follow-up appointments and disruption for children and families.
- Supports effective healing through an approach reported to be clinically and radiographically equivalent to a spica cast in a level I randomised controlled trial.

What action has been taken or is planned, and what impact has this had?

Measures of improvement

Implementation will be monitored through established governance arrangements, using patient outcomes, safety, length of stay, need for theatre treatment, follow-up demand and patient and family experience to demonstrate impact and identify further improvement opportunities.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

• Patient-reported safety and overall experience remained above the 85% benchmark in every reported month from April to August 2026.

• Tendable demonstrated positive IPC compliance, particularly in ANTT, linen management and several equipment and environmental standards.

• The ePMA DAL dashboard provides a new mechanism for ward, specialty and Clinical Board monitoring and improvement.

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 SOP for referrals and follow up, including defined documentation standards, tracking, escalation timeframes, and role clarity. Transition to digital clinic outcome recording, eliminating paper COFs and improving auditability of follow-up decisions.	No confirmed completion date	Digital support and pathway redesign are underway as part of the Health Board's Lost to Follow Up programme to reduce harm led by the deputy COO from patients lost to follow-up. Progress is ongoing but, due to resource and capacity limits, a completion date cannot yet be confirmed. Interim assurance is provided through continued programme oversight, recognition of the residual risk and prioritisation of safer documentation, tracking, escalation timeframes and role clarity. The action remains Amber because delivery is dependent on digital capacity and pathway redesign; continued scrutiny is	Amber

			required until a confirmed implementation date and measurable milestones are agreed.	

Top 5 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. 5) New process will be switched on 1/9/2026 that does not allow EPMA to produce a TTO without a DAL.

CLINICAL BOARD QUALITY UPDATE REPORT			
Governance Group:	MHCB QSE	**Date of Meeting:**	9 October 2026
Representative at Clinical Board Governance:	Mental Health Clinical Board	**Date of Next Meeting:**	12 November 2026

SUMMARY OF KEY ASSURANCE POINTS

The Mental Health Clinical Board Quality, Safety and Experience meeting occurred on the on 9 October 2026. Key alerts relate to rising concern volumes and timeliness, Mental Health Act statutory capacity and compliance, MHSOP inpatient acuity and safe staffing following the temporary move to East 4, infection prevention and control pressures in relation to bed bugs, and the ongoing response to Healthcare Inspectorate Wales findings for Meadow and Daffodil Wards.

There were 78 open concerns as at 5 October 2026. Adult Services accounted for 70, including 39 formal concerns outside the response timeframe. The leading themes were ADHD, change of consultant, service provision, communication and access to services.

MHSOP reported sustained acuity, enhanced observations and wards operating above commissioned 14-bed capacity. SafeCare red flags, Datix information and professional judgement are being triangulated, with temporary staffing uplifts used where required. Temporary ward moves linked to refurbishment, including East 14 moving to East 4, require additional staffing and daily and weekly review of falls, ligature and environmental mitigations.

The Mental Health Act Office reported an unsustainable workload within its current establishment, with senior staff regularly undertaking administrative work to maintain statutory activity. Risks include close calls involving sections lapsing, invalid Section 5(2) applications from general wards, inconsistent rights documentation, limited routine audit capacity and a medication authorisation failure.

Learning and improvement activity remains active. The six-month evaluation of Professional and Shared Learning Events found strong multidisciplinary value and positive feedback, while identifying the need for better attendance data, greater frontline participation, more interactive and case-based learning, and clearer evidence that learning results in measurable practice change.

ITEMS FOR ALERT

Issue / Risk	Actions taken	Group responsible
Concerns management is an alert. As at 5 October 2026 there were 78 open concerns across the Clinical Board. Adult Services held 70 concerns, including 66 formal concerns, of which 39 were out of time. The principal themes were ADHD, change	Directorate and Clinical Board oversight should focus on recovery of overdue responses, thematic learning and sustainable improvement in communication and access. For w/c 12 October 2026, drafted completed concerns are being shared between 3	Directorate Management Teams, Clinical Board Director of Operations, Psychology and Nursing.

of consultant, service provision, communication and access to services.	members of the Clinical Board for review and sign off to support timeliness of completion. ADHD-related demand and concerns require pathway consideration and will form part of MH Transformation Work. The immediate action is to complete a short pathway options review, including demand and capacity, waiting-list position, current clinical responsibility, prescribing and monitoring arrangements, transition from children's services, equality impact and patient communication. This should include consideration of a single intake and waiting-list governance process, clearer referral criteria, and a multidisciplinary model drawing on nursing, pharmacy, psychology, AHP and medical input where clinically appropriate. The intended outcome is to reduce variation, improve communication with patients and referrers, protect CMHT capacity for people with severe mental illness, and provide a safer, more equitable ADHD assessment and treatment pathway. This will report through the Mental Health Transformation Programme governance, with risks and progress visible through	

	Directorate and Clinical Board oversight.	
Mental Health Act statutory compliance and office capacity remain an alert. The current workload is described as unsustainable, with staff reporting stress and statutory work being carried forward. Risks include close calls involving sections lapsing, invalid Section 5(2) applications, inconsistent rights documentation, limited audit capacity and medication being administered for 33 days without a valid certificate.	Senior Mental Health Act Office staff are undertaking lower-band administrative work to protect statutory activity. Rights and Section 5 training videos have been recorded and uploaded to the MHA SharePoint site. Guidance has been circulated to clinicians, Responsible Clinicians have been reminded to review daily reports, and local diary checks have been reinforced. A sustainable establishment and administrative support solution remains required and Risk Assessment/ SBAR being completed . Further work is being taken forward with People Services to support the Mental Health Act Office team, recognising the reported stress, workload pressure and risk of senior staff being diverted from specialist statutory functions. This will include reviewing the current establishment, skill mix and administrative support requirements, alongside appropriate staff wellbeing support, return-to-work and workforce planning arrangements. There is evidence of statutory non-compliance and near misses, although we do not yet	Mental Health Act Office MHCB Responsible Clinicians and ward teams

	have sufficiently robust quantified data to describe the full extent of this. Issues identified include invalid Section 5(2) applications, inconsistent rights documentation, close calls in relation to sections lapsing and one identified incident where medication was administered for approximately 33 days without a valid CO3 certificate. Following this incident, current patients across the unit were checked and certificates were confirmed as present and in date where required, with no further comparable issue identified at that point. Immediate controls have been strengthened. Responsible Clinicians are being asked to review their Mental Health Act reports at least weekly and ahead of ward rounds, with CO2/CO3 certificate status incorporated into ward-round checking. The Mental Health Act Office has reconciled its monitoring spreadsheets and periodic nursing spot checks have also been agreed. Guidance relating to Section 5(2) is available through the MHA SharePoint site and is being reinforced with clinical teams, alongside further analysis of invalid applications	

	and escalation across the wider Health Board. The underlying concern remains capacity. The Mental Health Act Office currently has an establishment of 6.16 WTE, with senior Band 6 and Band 7 staff routinely undertaking Band 3 and Band 4 administrative work. This reduces capacity for assurance, audit, training and Section 117 work. The establishment SBAR identifies a minimum requirement for an additional 22.5 hours per week of permanent Band 3 administrative capacity, increasing to 37.5 hours if the Office is to fully support its training, audit and records-management requirements. The risk is being progressed through the establishment SBAR and formal risk assessment, alongside consideration of establishment, skill mix and administrative support requirements. The intention is to protect specialist Mental Health Act capacity by reducing the amount of routine administrative work undertaken by senior staff and restoring capacity for assurance, audit and training.	

	There is therefore some immediate assurance that strengthened controls are in place and that the specific certificate issue prompted wider checking. However, we do not yet have sufficient evidence to provide assurance that these controls are sustainably addressing the underlying risk. The establishment SBAR is being strengthened to include quantified backlog and compliance information, workforce capacity, audit and training activity, and measurable outcomes. The Mental Health Act Office risk will therefore remain visible through Clinical Board governance until there is sufficient evidence that the controls are effective and sustainable.	
MHSOP capacity, acuity and safe staffing remain an alert. Several wards are operating above commissioned 14-bed capacity while managing enhanced observations and sustained operational pressure. Refurbishment-related ward moves, including East 14 moving temporarily to East 4, introduce additional falls, ligature and environmental risks.	SafeCare red flags, Datix trends and professional judgement are being reviewed together. For the East 14 move, two additional long-day shifts and two additional night shifts have been requested, with daily ward review and formal weekly review of the mitigations. This was completed in SBAR format, and an ask has been made for a Quality Impact Assessment to be undertaken and reviewed aligned with any mitigations identified.	Lead Nurse MHSOP QIA Received 12/10/26 and authorised by Deputy Director of Nursing, Director of Operations and sent to exec for consideration. Now requiring 1 extra staff member rather than 2.

Healthcare Inspectorate Wales improvement activity for Meadow and Daffodil remains under close oversight. An NMC exceptional report is required for the practice-learning environment following publication of the inspection report, and an improvement-plan review with university partners has been arranged. Outstanding actions must be current, evidenced and appropriately governed.	The improvement plan has been updated and shared for review. A meeting with university representatives is arranged for 14 October 2026 to consider the exceptional report and associated assurance. Actions remain tracked through AMAT and Clinical Board governance. There are 6 overdue actions related to estates, estates have reported completion but for assurance, the ward managers will review to confirm actions this week. An overarching themed HIW improvement plan is in development to ensure sustained improvement and oversight by November 2nd. This includes Monthly MHCB ward walkabouts, with two MHCB members attending alongside Facilities and Estates.	Adult Mental Health Directorate MHCB Nursing Leadership ECOD and university partners
Infection prevention and control remains an alert within MHSOP because a recurrent scabies outbreak has been identified. Recurrence highlights the risk of reinfection when affected individuals and close household contacts do not complete treatment concurrently or follow environmental measures.	IPC advice has been sought, treatment and contact-management actions have commenced, and communication with families has been strengthened. The ward is monitoring completion and any further cases, with prompt escalation to IPC. East 12 was closed for 1 week in October for full treatment to be given to everyone. No out of area provided. IPC are working with the team to determine if scabies or a different outbreak. This work is ongoing 20/10/2026. Given the nature of the concerns weekly IPC audits will	Ward Management Team IPC Team MHSOP Senior Nursing Team

	be completed for the next 4 weeks, and will review following data collected.	
Since 1st October there have been concerns reported in relation to bed bugs on Oak, Meadow and Willow Ward leading to ward closures to admissions and transfers. Coms have been alerted, and have had information on the plan.	• Oak Ward: Now clear. Rooms can proceed to deep cleaning and reopening. • Meadow Ward: Requires wardrobe removal and detection dog assessment, with fumigation if indicated. Ward to remain closed to admissions and transfers until resolved. • Willow Ward: Primary area of concern. Bed and wardrobe require specialist removal before detection dog assessment. All ward areas, furniture and surfaces will be checked, followed by targeted fumigation where required. Ward to remain closed to admissions and transfers. • IP&C: To audit the condition of furniture. Core IP&C audits to be completed by the Clinical Senior Nurse. • Estates/Housekeeping: Specialist contractor required for bed removal, with AGS identified due to the need for appropriate protective equipment. • Detection dog: Housekeeping to arrange attendance, subject to contractor availability (confirmed attendance 22/10/2026). • Patient safety: Ward teams to identify patients with dog allergies and put appropriate mitigating care plans in place. • Infection prevention measures: Relevant patients to regularly change	IPC Leads, Lead Nurses, Director of Nursing, Estates, Directorate Manager

	clothing and bedding and clean these in accordance with IP&C advice. Staff to follow IP&C guidance on uniform washing and report any concerns promptly.	
ITEMS TO ADVISE		
Issue / Risk	**Actions taken**	**Group responsible**
Neurodevelopmental demand and concerns remain a material issue. The October concerns report identifies ADHD as the leading concern theme, alongside access to services, service provision, communication and change of consultant. This continues to affect patient experience and operational resilience.	Waiting-list, pathway and complaint themes remain under Directorate and Clinical Board oversight. Work should continue on consistent communications, referral guidance and the strategic response to demand and capacity. Joint meeting planned with children's and womens October 2026.	Adult Mental Health Directorate Psychology and Psychological Therapies Concerns Team MHCB
Sexual safety and the future model for mixed-gender inpatient wards require further review. Existing improvement actions include updating the SBAR on the feasibility of single-sex provision, strengthening incident reporting and safeguarding awareness, and improving staff training.	Initial discussions have commenced with ward managers, peer-training and psychology colleagues. A five-year dataset is proposed covering safeguarding and Datix incidents, enhanced observations, staffing, admissions, out-of-area transfers, delayed discharges, length of stay, patient and family feedback, and ward moves linked to sexual-safety concerns. Findings are intended to inform a wider options review.	Adult Mental Health Directorate MHCB Patient Safety and Safeguarding governance
The governance of commissioned out-of-area patients remains an area for advice. As of 12 October 2026, the number **remains 10.**	All silver on-call have been informed executive authorisation is now required for OOA beds. The SOP developed has been circulated, and now expectation is that is that the SOP enacted. Outstanding information on the OOA SOP which focuses on all commissioned and non-commissioning team expectations has been	Complex Care and Commissioning Adult Mental Health Directorate MHCB Controlled Documents Oversight Group

	requested, after which the document will proceed to consultation and the Controlled Documents Oversight Group.	
The Neuropsychiatry service remains under JCC review, with limited clarity on the future service model, strategic direction and performance framework. This affects service development, workforce planning and the ability to align improvement priorities with future commissioning expectations.	The matter will remain visible through Directorate and Clinical Board governance while further direction is sought. Once commissioning expectations are clarified, the service will review key performance indicators, outcomes and its approach to demonstrating quality, rehabilitation outcomes and value.	JCC Commissioners MHCB MHSOP and Neuropsychiatry Directorate
The tier 3 Eating Disorder Service (formerly known as SHED) remains under MHCB and Executive assurance following an internally commissioned review (36 degree). Clinical and workforce concerns were identified and an immediate and assurance plan actioned	This remains under constant review and oversight. The plan is to develop a fully integrated single pathway incorporating the tier 2 and tier 3 services. Recruitment has been successful. An experienced Lead from London has been secured and has confirmed a starting day of December 15 2026. Patients are regularly reviewed and a more formal audit was undertaken in September.	MHCB. Director of Psychology and Director of Operations. DMT AMH and DMT Psychology & Psychological Therapies
ITEMS FOR ASSURANCE		
Issue / Risk	**Actions taken**	**Group responsible**
The Professional and Shared Learning Events programme provides assurance that a structured, themed multidisciplinary learning forum is established. Feedback is overwhelmingly positive, with participants valuing the learning opportunities, facilitation, multidisciplinary perspectives and thematic format.	The next phase will introduce a standard attendance dataset, more interactive and case-based learning, a learning-to-action process with named owners and timescales, and follow-up reporting on implementation and impact. Frontline participation and accessibility will be prioritised.	MHCB Nursing and Quality Leadership Learning Event Leads Directorate Management Teams
Maple Ward has strengthened controls for preventing, detecting and responding to illicit substance use. Current measures include enhanced risk review, drug screening	Staff support includes induction on drug-screening processes, substance-awareness and harm-reduction education, overdose awareness, and partnership working with	Adult Mental Health Directorate Maple Ward Addictions and Pharmacy services

where indicated, environmental and bedroom checks, visitor controls, body scanning and escalation routes involving police support where necessary.	specialist substance-misuse services. Bromazolam awareness information was shared through the October QSE learning agenda. This information has been gained via the ABP after a concern was raised by a family member that there was a lack of knowledge regarding Bromazolam. This is s substance identified as a contributory factor to the patients death.	
Datix Total reduced from 1,386 in September 2025 and 1,219 in August 2026 to 883in September Current position753 in total. This includes 362 no harm, 222 low harm, 139 moderate, 8 severe, 21 catastrophic/death.	Continue with targeted work and weekly moderate and above tracker. Continue to review directorate datix plans.	Lead Nurses/ Director of Nursing.

RECENT LEARNING OPPORTUNITY			
Source:	Professional and Shared Learning Events six-month evaluation	**Reference (if applicable):**	Evaluation report presented to MHCB QSE, 9 October 2026
What happened / what was the problem?			
The evaluation found that the programme provides a structured and valued forum for learning across patient safety, governance, co-production, legal frameworks and clinical practice. However, attendance records were not sufficiently consistent to establish reach by profession, directorate or frontline role, and the evidence of learning translating into measurable service change was variable.			
What was learned and how was this shared?			
The themed model and multidisciplinary approach are valued and should be retained. Future events need stronger frontline participation, more interaction and applied case-based learning, standard attendance and evaluation data, and a clearer line from learning to agreed actions, implementation and measurable impact.			
What action has been taken or planned? What was the impact of this?			
A standard event dataset and consistent evaluation framework will be introduced. Each event should record key learning, actions, owner, timescale and governance route, with a subsequent “You said, we did, impact achieved” update. Communications and delivery will be adapted to increase access for ward and community staff. The intended impact is stronger assurance that learning is reaching the workforce and changing practice.			

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

The Professional and Shared Learning Events programme continues to provide a credible multidisciplinary platform for patient-safety reflection, lived-experience contribution and improvement learning. Maple Ward has embedded strengthened substance-misuse risk, security and staff-awareness controls. The Clinical Board is also progressing a more structured review of sexual safety and future inpatient ward models, using patient, family, workforce and operational data to inform options.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non-Delivery	Risk (RAG)
	Protocol for harmful substances	Originally due September 2026; final ratification route outstanding.	The harmful-substances protocol was approved by the MHCB Controlled Documents Oversight Group, and has been discussed at the Medicines Safety Group 25 September 2026. The SOP is now with PCIC for final consideration, before it goes back medicines safety for ratification.	Amber
	Complex Emotional Needs Pathway	Revised completion: December 2026.	The pathway requires completion of the psychological-interventions component and alignment with the urgent pathway work within the Mental Health transformation programme. Governance has been strengthened through the transformation structure, but the final pathway is not yet complete.	Red

NEW / CLOSED / AMENDED RISKS

New and amended risks requiring continued oversight include: MHSOP capacity, acuity and safer staffing, including temporary ward moves; recurrent scabies and associated outbreak control; Mental Health Act Office capacity and statutory compliance; concern volumes and response timeliness; and the continuing HIW improvement and exceptional-report process for Meadow and Daffodil. The MHSOP risk register is being reviewed to ensure risks, controls, evidence and scores reflect the contemporary position. No risk should be reduced or closed without sufficient evidence that controls are effective and sustained. Existing risks relating to out-of-area care, patient flow, Complex Emotional Needs, neurodevelopmental demand, environmental safety and workforce

resilience remain subject to the established Directorate, QSE, Clinical Board and executive escalation routes.

In addition, environmental and infection prevention risks linked to IP&C across Oak, Meadow and Willow require continued oversight until specialist assessment, deep cleaning, fumigation where indicated, and safe reopening arrangements are fully completed. The East 14 temporary move to East 4 also requires continued monitoring through the approved QIA/SBAR process, with staffing mitigations reviewed daily and formally weekly. The Mental Health Act Office establishment risk should remain visible until the SBAR, risk assessment and People Services review have concluded and a sustainable administrative support model is agreed. ADHD and wider neurodevelopmental demand should remain an amended risk due to the sustained growth in waiting times, concerns activity, and impact on access, patient experience and CMHT capacity.

Report Title:	Clinical Effectiveness Committee Highlight Report		Agenda Item No:		7.2
Meeting:	Quality Committee	Public	x	Meeting Date:	27.10.2026
		Private			
Lead Executive Title:	Executive Medical Director				
Report Author/s Title:	Assistant Director of Quality and Patient Safety				

Report Focus Summary – **AAA Framework:**

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

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

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

The National Audit of Metastatic Breast Cancer audit contains 10 performance indicators, but reporting of Welsh performance is currently limited to four, significantly restricting the assurance that can currently be derived from the audit. Data submission in Wales for the National Audit of Primary Breast Cancer allows scrutiny of all performance indicators. There is ongoing work being undertaken nationally to ensure parity of reporting with England. Since 2023 health organisations in Wales are using a standard cancer data set form which is anticipated to improve data collection.

Challenges in data submission relating to adjuvant chemotherapy and radiotherapy for welsh organisations has resulted in inaccuracies in reporting, undermining the ability for benchmarking but publication of data that is misleading and could cause public anxiety. The 2026 reports state that 44.6% of patients with de novo metastatic breast cancer and 15.5% of patients with primary breast cancer cared for in the UHB are recorded as receiving chemotherapy and 19.6% of patients with primary breast cancer are recorded as receiving radiotherapy. Arrangements for collection and submission of adjuvant therapy data are now in place within Velindre NHS trust and moving forward should mean that Cardiff and VAle UHB rates are accurately reflected.

Triple diagnostic assessment performance in the UHB is at outlier status, below the 95% confidence interval (9.5%). Constraints in delivering and reporting imaging has resulted in all women over 40 attending a mammogram / tomosynthesis appointment ahead of attending for a clinical assessment. A radiology action plan is in place to improve access and might be able to support a return to single-attendance triple assessment in the future.

Immediate breast reconstruction rates were reported as comparatively low during the audit period, and below the national mean. More recent local audit data demonstrates improvement, increasing from approximately 15.3% to 26%, with further work planned to better understand barriers to reconstruction uptake. Development of a local perforator flap pathway in collaboration with plastic surgery is allowing delivery the option of lumpectomy to more women, including those with larger lumps or smaller breasts and it is hoped that this will support evidence of increased breast-conserving surgery in future audit publications.

The audit report indicated an increased UHB reoperation rate. The reoperation rate following lumpectomy due

to involved margins was reported at over 24.8% compared with a UK average of approximately 16.4% and a Wales average of approximately 19%. Individual reoperation cases are reviewed by surgeons and radiology to understand the reasons. In some cases, limitations in imaging has resulted in an underestimation of the tumour size, The availability of intraoperative X ray allows scrutiny of the lump to ensure that it is removed in totality and the department are exploring the possibility of contrast enhanced mammogram.

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

Three-year survival outcomes for primary breast cancer were 98.1% in line with the UK average (97.7%) providing assurance regarding overall patient outcomes despite the identified challenges in specific process measures.

Cardiff and Vale was among the higher-performing organisations for Clinical Nurse Specialist (CNS) contact following diagnosis of metastatic breast cancer and also performed above average for CNS contact following diagnosis of primary breast cancer. 88.7% of patient diagnosed with De Novo metastatic breast cancer and 85.2% of women with primary breast cancer were discussed at a multi-disciplinary meeting above the UK mean in both audits.

Performance for multidisciplinary team (MDT) discussion following metastatic breast cancer diagnosis was above the national average with 83.9% of patients with De Novo Metastatic Breast Cancer discussed.

English Health organisations are able to access quarterly audit reports with a one-year lag, supporting a responsive quality improvement approach, Wales has been limited to receiving the annual report with data relating to care provision three years prior. From early 2027 Wales will also be able to access data on a quarterly basis.

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

Recommendations

The Committee should:

1. **NOTE** the assurance provided by the clinical performance reported in the National audits and the improvement work that is underway to address requisite improvement

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

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

Main Report
Background & Current Situation

The Clinical Effectiveness Committee met on 23rd September 2026 to hear presentations and assurance relating to associated improvement plans for the National Audit of

Metastatic Breast Cancer and the National Audit of Primary Breast Cancer 2026 reports relating to care provided in 2021-2023. The Minutes are provided in Appendix 1.
Appendices:
• Appendix 1 Minutes of the Clinical effectiveness Committee 23rd September 2026
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: No
Safety: Yes
Reoperation, and breast conserving surgery rate as well as immediate reconstruction rates are beyond the national mean and at present available of triple diagnostic clinics is very limited.
Financial: Yes
Workforce: Yes
The audits identify excellent performance around CNS
Legal: No
Reputational: Yes
National data collection has resulted in inaccurate performance reporting around adjuvant therapies.
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Clinical Effectiveness Committee

Wednesday 23rd September 2026

10:30-12:00

Attendance list		
Name	**Role**	**Initials**
Aled Roberts	Chair and Assistant Medical Director Quality and Safety	AR
Alexandra Scott	Assistant Director of Quality and Patient Safety	AS
Suzie Cheesman	Deputy Head of Safety, Quality and Organisational Learning	SC
Jim Pullen	Patient Safety Facilitator	JP
Cath Evans	Deputy Head of Patient Safety	CE
Clare Wade	Director of Nursing Surgery Clinical Board	CW
Anna Powell-Chandler	Consultant Breast Surgeon	APC
Kenneth Lim	Consultant Obs and Gynaecology	KL

Item	Detail
	Welcome and actions
1.1	AR welcomed members to the meeting. Apologies were received and noted for Abri Theron and Andy Jones.
2	**National Clinical Audit presentations**
2.1 and 2.2	Anna Powell-Chandler (APC) presented the National Audit of Metastatic Breast Cancer and National Audit of Primary Breast Cancer <u>National Audit of Metastatic Breast Cancer – State of the Nation Report 2026</u> • Reports on patients diagnosed with metastatic breast cancer between 2021 – 2023. • The audit contains 10 performance indicators, but Wales is currently only able to submit information against four, significantly restricting the assurance that can currently be derived from the audit. • Across Wales, the audit identified 442 patients with de novo metastatic breast cancer and 600 with recurrent metastatic breast cancer during the three-year reporting period. *De novo breast cancer is breast cancer that has already spread to a distant part of the body when the patient is first diagnosed with*

	breast cancer. It is therefore metastatic at initial presentation, rather than breast cancer that was previously treated and subsequently recurred or metastasised. • Ascertainment of de novo metastatic disease is considered relatively reliable, whereas recurrent metastatic breast cancer is likely to be under-recorded. Accordingly, the figure of 600 recurrent cases is likely to underestimate the number. Key findings for Cardiff and Vale: • Data completeness was generally strong for CNS contact, oestrogen receptor status, HER2 receptor status and tumour grade, with the UHB meeting or approaching the 90% completeness expectation for most of these measures. • Cardiff and Vale was one of the higher-performing organisations for CNS contact following metastatic breast cancer diagnosis. AS asked whether the strong CNS contact performance translated into positive patient experience. APC advised that breast cancer patient reported outcome measures are due to be introduced nationally through the Welsh cancer arrangements and patient experience has previously been assessed intermittently through local projects and has generally generated positive feedback. • Cardiff and Vale was above the national average for MDT discussion following a metastatic diagnosis. • The Breast Service has introduced a process whereby all patients known to have metastatic breast cancer are discussed at MDT, supporting both clinical oversight and improved case identification. • Metastatic breast cancer champions are in place within Welsh health boards to liaise with MDT coordinators and improve the completeness and accuracy of metastatic cancer data. • Stage recording remained poor, consistent with the position across other Welsh health boards. This is particularly significant because accurate staging is central to identifying patients with metastatic disease. • Recording of recurrent metastatic disease was acknowledged to be substantially less complete than recording of de novo metastatic disease. This limits the ability of the audit to describe accurately the total metastatic patient population and the care subsequently received. • The reported use of chemotherapy was low across Welsh health boards however this was unlikely to provide an accurate representation of clinical practice, due primarily to limitations in capturing systemic anti-cancer therapy data. Patients' systemic anti-cancer therapy and radiotherapy are delivered outside Cardiff and Vale by Velindre Cancer Centre, while the resulting

national audit performance is attributed to Cardiff and Vale. Local cancer coordinators can enter treatment information but there is uncertainty concerning where responsibility sits for completing these fields.

- Work is being considered to obtain treatment information automatically from chemotherapy care records and radiotherapy records, which could improve future reporting.
- AS asked whether responsibility between the organisations had been explicitly agreed around data collection for adjuvant therapies, noting the possibility that each organisation could believe responsibility rested with the other. AS agreed to examine whether similar problems were evident in other national cancer audits. APC agreed to facilitate contact with NHS Performance and Improvement team to clarify responsibility and current work to resolve the problem
- Six of the metastatic audit's ten indicators are not currently reportable in Wales. Work is under way to amend datasets and for quarterly reports to be available in 2027.

<u>National Audit of Primary Breast Cancer</u>

- The Primary Breast Cancer Audit contains 10 performance indicators, with Wales able to submit data against all ten.
- Cardiff and Vale demonstrated a mixed position, with several areas of positive practice but also important clinical and data quality issues requiring continued scrutiny.

Key findings for Cardiff and Vale

- CNS contact following a diagnosis of primary breast cancer was good and above average, consistent with the positive finding within the metastatic audit.
- Cardiff and Vale was reported as performing poorly for triple diagnostic assessment. The standard requires patients referred with suspected breast cancer to receive, where clinically indicated, clinical assessment, breast imaging and biopsy during the same hospital attendance.
- In Cardiff and Vale women aged over 40 referred with suspected breast cancer currently generally undergo mammography at one attendance followed by clinical assessment, ultrasound and biopsy where required at a subsequent clinic. Women under 40, who do not routinely require mammography, can generally continue through the single-clinic pathway.
- The service has also moved from two-dimensional mammography to tomosynthesis which provides more detailed imaging but requires additional time.

	• A radiology action plan is in place within the Breast Unit with the intention of improving radiology access and, where possible, enabling a return to triple diagnostic assessment. • Breast-conserving surgery was reported at just under 70%, leaving a relatively high mastectomy rate. several legitimate clinical and patient-choice factors influence this measure, including tumour characteristics and patients choosing mastectomy despite being suitable for breast-conserving surgery. Nevertheless, the service recognised the need to continue monitoring the position. • The national audit reported Cardiff and Vale's immediate breast reconstruction rate at approximately 15%, which was on the lower side nationally for the period reported. More recent local re-audit indicates that the rate has subsequently increased to approximately 25%, suggesting improvement since the 2021-2023 cohort. Further work was considered necessary to understand why some patients are not offered reconstruction and why others elect not to proceed with it. • The Committee heard positively that a plastic surgeon is working with the Breast Service to develop a local perforator flap pathway. This could enable breast-conserving surgery for some patients with larger cancers or smaller breasts who might otherwise require mastectomy. • A significant area for improvement was the reoperation rate following lumpectomy because of involved margins. The reported UK average was approximately 16%, the Wales average approximately 19%, compared with over 25% for Cardiff and Vale, making the UHB an adverse outlier for this measure during the audit period. The service routinely audits re-excision cases and reviews these through local audit and/or morbidity and mortality meetings. Reasons identified include cancers proving significantly larger at surgery than predicted from pre-operative imaging. Measures already introduced include acquisition of an improved X-ray machine for intra-operative specimen imaging, enabling better assessment of whether the lesion has been adequately excised. The service is also seeking access to contrast-enhanced mammography, which may improve pre-operative assessment in cases where conventional imaging underestimates tumour extent. Radiologists have also undertaken review of the relevant cases for learning following previous presentation of the reoperation data. • Importantly, the three-year survival was above average and consistent with the level expected, providing positive outcome assurance despite the identified issues relating to repeat surgery and data quality.

	Action: AS to examine whether similar problems re chemotherapy data collection were evident in other national cancer audits. APC agreed to facilitate contact with NHS Performance and Improvement team to clarify responsibility and current work to resolve the problem.
2.3	**National Ovarian Cancer Audit** Postponed to 16th October
4.1	**Any Other Business**
5	**Next meeting**
	The next meeting will be held on 26th November 2026 **via Microsoft Teams.**

Report Title:	Summary of Recent Healthcare Inspectorate Wales (HIW) Inspection Reports		Agenda Item No:		7.3
Meeting:	Quality Committee	Public	X	Meeting Date:	29.09.2026
		Private			
Lead Executive Title:	Executive Nurse Director				
Report Author/s Title:	Assistant Director of Quality and Patient Safety				

Report Focus Summary – **AAA Framework:**

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

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

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

Andrew Thomas Dental Care underwent and inspection in June 2026 and the report was published in September 2026. The practice was issued with a small number of recommendations relating to environmental improvements in the decontamination room, strengthening of two policies, resilience of first aid provision and the provision of patient information relating to the risks and benefits of dental X rays. Clear plans were developed and accepted by HIW to address these recommendations.

There is continued oversight of HIW improvement plan progress across Clinical Boards. Work is underway to develop a three-month update of the improvement plan relating to Llanfair unit inspection undertaken in June 2026, published in September 2026 and reported to the September Quality Committee, with good progress made.

Work is underway in Mental Health Clinical Board to embed the learning from combined HIW inspections undertaken in the past 12 months and to strengthen oversight and assurance across all mental health inpatient wards. This includes:

- Oversight of the patient environment to ensure optimal patient experience and effective infection prevention and control.
- strengthening processes to ensure compliance with mandatory training including Strategies and Interventions for the Management of Aggression (SIMA)
- Adherence to agreed nursing establishments
- Documentation of risk assessments and care and treatment plans

An update will be provided to the Committee in November 2026 on progress against these assurance measures.

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

- Andrew Thomas Dental Care provided a high standard of care with good patient experience noted, including friendly and welcoming staff and dental team and facilitation of a short notice list used to fill cancelled appointments.
- Good progress continues with local HIW improvement plans across the UHB and clinical audit has been planned in a number of wards to provide assurance around the sustained improvements. These areas include:
    - Maple Ward – Adult Mental health
    - Hamadryad Community Mental Health Team
    - Short Stay Surgical unit

- B2 Link (Vascular)

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

Recommendations

The Quality Committee is asked to:

A. **Receive assurance** regarding the actions taken in response to recent HIW inspection findings across primary care services, note the progress of associated improvement plans, and endorse the continued organisational learning arising from inspection activity. The practice provided safe and effective care with good Infection prevention and control arrangements. Governance arrangements were effective with patient feedback mechanisms and complaints processes in place.

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

Health Care Inspectorate Wales has published one Primary Care report. One Secondary Care report was published in September 2026 relating to Llanfair Unit, (Adult Mental Health) in September 2026. Details of this report were included in the HIW report to the committee in September 2026.

Primary Care

- Andrew Thomas Dental Care underwent a general Dental practice Inspection on 2nd June 2026 and the report was published on 2nd September 2026

An announced inspection of Andrew Thomas Dental Care found that the practice provided a high standard of patient-centred care, with patients reporting very positive experiences, clear communication, involvement in treatment decisions, and good access to appointments. Inspectors found the practice to be well led, with effective governance arrangements, strong safeguarding processes, good infection prevention and control measures, safe management of medicines, and well-maintained patient records. No immediate patient safety concerns were identified. Areas for improvement included upgrading aspects of the decontamination room, formalising business continuity arrangements, strengthening the risk management policy, ensuring sufficient first aid cover, and displaying information on the benefits and risks of dental X-rays for patients.

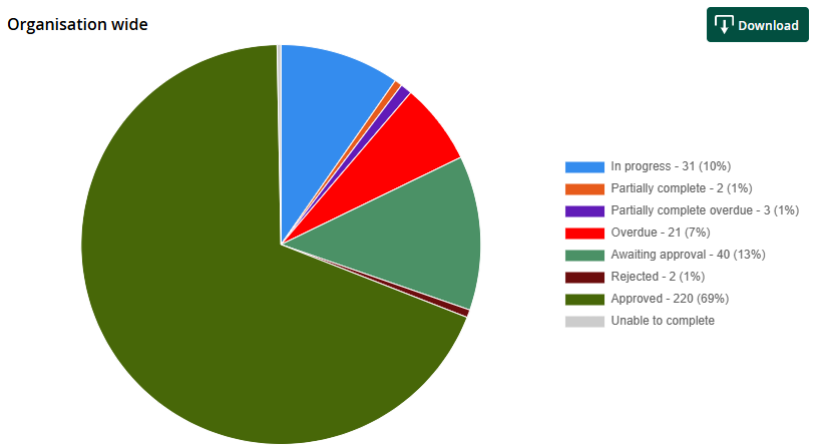
No immediate concerns or noncompliance issues were noted.

The full report can be read at 20260602AndrewThomasDentalEN.pdf

Organisational learning from secondary care inspections

Secondary care HIW inspections are subject to ongoing oversight by the Clinical Boards with scrutiny from the Executive Directors through structured performance reviews. Monitoring of progress against HIW improvement is undertaken through the AMaT clinical governance system,

and the chart below shows progress against secondary care improvements that remain in progress over the past 12 months



Primary Care Assurance

Following receipt of an HIW report, a Primary Care Development Manager will contact the practice to discuss the findings and to agree a plan for the submission of improvement or action plans. Practices are requested to provide a copy of their completed action plan to the Primary Care Team to enable ongoing monitoring and assurance of progress against identified actions. The primary Care Team have continued oversight of these improvement plans and the progress made.

Where an inspection identifies matters requiring immediate assurance, the practice will be contacted promptly to discuss the required actions and the timeframe within which an immediate assurance action plan must be submitted.
For actions relating to clinical practice, monitoring and follow-up will be undertaken by the Senior Nurse for Primary Care and/or an appropriately qualified clinician to ensure that actions have been completed satisfactorily and that compliance with relevant clinical standards has been achieved.

For actions relating to operational processes, governance arrangements or administrative procedures, the practice will be required to provide evidence demonstrating that the necessary improvements have been implemented. This evidence will be reviewed by the Primary Care Team and further assurance will be sought through the Contract Assurance Framework (CAF) process to confirm that revised processes and procedures have not only been implemented but have become embedded within routine practice.

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

Impact Assessment
Risk*:* Yes
inspection findings identified risks requiring monitoring and action plans.
Safety*:* Yes
inspection findings relate directly to quality and patient safety.
Financial*:* No
Workforce*: Yes*
Actions include training, staffing, leadership, and culture improvements.
Legal*:* No

Reputational: Yes
HIW inspection reports are published in the public domain.
Socio Economic*:* No - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health*:* No
Decarbonisation*:* No
Welsh Language*:* No

Report Title:	Public Services Ombudsman for Wales Annual Letter 2025-26		Agenda Item No:		7.4
Meeting:	Quality Committee	Public	X		27.10.2026
		Private			
Lead Executive Title:	Executive Nurse Director				
Report Author/s Title:	Assistant Director of Patient Experience				

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

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

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

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

The Public Services Ombudsman for Wales Annual Letter 2025-26 provides independent assurance on complaint activity and outcomes for Cardiff and Vale University Health Board. During 2025-26, 230 complaints were received and 216 were closed. The Ombudsman intervened in 18% of cases closed, compared with 22% across health boards. The Health Board complied on time with 71% of the 92 recommendations falling due, slightly above the Wales position of 69%. Continued improvement is required in timely compliance with recommendations and in applying learning from the Ombudsman's findings.

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

Recommendations

The Quality Committee is asked to:

1. **Note** the Health Board's complaint, intervention and recommendation-compliance performance.
2. **Support** continued monitoring of outstanding and future Ombudsman recommendations through established governance arrangements.

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

Purpose
This paper presents the Public Services Ombudsman for Wales Annual Letter 2025-26 for Cardiff and Vale University Health Board. The Ombudsman asks that the Annual Letter and associated data are presented through the Health Board's governance arrangements, reviewed alongside local data and used

to inform improvement.

National context
The Ombudsman reported its busiest year on record, with 4,507 duly made complaints across public services and Code of Conduct remits. Across health boards, 1,351 complaints were received, a 42% increase from the previous year. Clinical treatment in hospitals remained the most frequent source of concern. The Ombudsman intervened in 22% of health board complaints closed.

Health Board position
During 2025-26, the Ombudsman received 230 complaints about Cardiff and Vale University Health Board and closed 216. Of the cases closed, 38 resulted in intervention, representing an intervention rate of 18%. This was lower than the 22% position across health boards. The principal category was clinical treatment in hospital, accounting for 120 complaints or 52% of complaints received.

Recommendations and compliance
The Ombudsman made 86 new recommendations in cases closed during the year. A total of 92 recommendations fell due during the reporting period, of which 71% were completed within the agreed timescales. This was slightly above the Wales position of 69%, but timely compliance remains an area for improvement. The Ombudsman has advised that a reasonable extension requested on or before the original deadline will be recorded as on-time compliance where the revised date is met.

Learning and improvement
The Annual Letter highlight national learning relating to waiting-list management, prescribing practice, urgent cancer referrals, ophthalmology, complaint investigation quality, openness and transparency, and Duty of Candour. Compliance with Ombudsman recommendations is closely monitored by the Patient Experience Team.

Conclusion
The Annual Letter provides assurance that the Health Board's intervention rate was below the all-Wales health board position and that recommendation compliance was slightly above the Wales average. Further focus is required to improve timely compliance and demonstrate that learning from Ombudsman findings is translated into sustained improvement.

Appendices:

- Appendix 1: Public Services Ombudsman for Wales Annual Letter 2025-26 – Cardiff and Vale University Health Board.

Strategic Alignment – Shaping Our Future Wellbeing:

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

Impact Assessment

Risk: Yes

The Annual Letter identifies risks relating to timely compliance with Ombudsman recommendations, complaint investigation quality, openness, Duty of Candour and organisational learning. These require continued oversight through established governance arrangements.

Safety: Yes

The national themes include clinical treatment, waiting-list management, prescribing practice, urgent cancer referrals and ophthalmology. Relevant learning should be considered alongside the Health Board's quality and safety intelligence.

Financial: No

Not applicable. No new financial commitment is requested through this assurance paper.

Workforce: No

Not applicable. No specific workforce decision is requested. Staff capacity and ownership remain relevant to delivering recommendations within agreed timescales.

Legal: Yes
The paper concerns the Health Board's response to recommendations made by the Public Services Ombudsman for Wales and references the statutory Duty of Candour. Timely, evidenced compliance supports legal and regulatory assurance.
Reputational: Yes
Failure to comply with recommendations or demonstrate learning may affect public confidence and the Health Board's reputation. Active monitoring and escalation mitigate this risk.
Socio Economic: No
Not applicable. The report is presented for assurance and does not contain a strategic decision or propose a service change.
Equality & Health: No
Not applicable. The paper does not propose a new or changed policy, plan, procedure or service requiring an Equality and Health Impact Assessment.
Decarbonisation: No
Not applicable. No direct decarbonisation implications have been identified.
Welsh Language: Yes
The Annual Letter is available in Welsh and English. Any resulting communication or action should continue to meet Welsh Language Standards and respect patients' language preferences.

Ombwdsmon
Ombudsman
Cymru · Wales

Ask for: Complaints Standards
01656 641150
Caseinfo@ombudsman.wales

Date: 17 September 2026

Ms Kirsty Williams
Chair
Cardiff and Vale University Health Board

By email only
Kirsty.williams30@wales.nhs.uk

Dear Kirsty

Annual Letter 2025-26

Our role

As the Public Services Ombudsman for Wales, we independently consider complaints about public services and investigate alleged breaches of the councillor Code of Conduct. We also set complaints handling standards for public bodies, drive continuous learning from complaints and undertake investigations into public services on our own initiative.

Purpose of this Annual Letter

This letter provides an update on our work for this period, and highlights key trends in Welsh health and public service complaints. It details performance specific to your organisation and outlines the positive actions we would like you to take.

Overview - a record-breaking year

This letter, as always, coincides with the publication of our Annual Report, which holds special significance this year as we mark our 20th anniversary. We closed our busiest year on record where the office received 4,507 duly made complaints across its public services and Code of Conduct remits — 27% more than last year, 47% more than 3 years ago, and 3 times as many as 20 years ago.

To meet this demand, we closed a record number of complaints, 29% more than last year and 43% more compared with 3 years ago. We intervened in 568 of complaints that we closed.

ombwdsmon.cymru
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac ymateb i ohebiaeth yn y Gymraeg.

ombudsman.wales
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
We are happy to accept and respond to correspondence in Welsh.

Finding swift resolutions to complaints, where possible, remains important to us and benefits all parties involved. This year, 85% of our interventions included an element of Early Resolution, a process we hope has proved valuable to both your organisation and to complainants.

Despite the increased volume of cases, our case handling times remained efficient. Initial assessments and Early Resolutions were completed within 4 weeks - well ahead of our 6 week target. Additionally we maintained a downward trend in our average investigation time which was 54 weeks this year from 64 weeks in 2023-24.

Overview of health board complaints

During 2025-26, we received 1,351 complaints about health boards marking a significant 42% increase from the previous year. Clinical treatment in hospitals remains the most frequent source of concern. Additionally, complaint handling accounted for approximately 14% of complaints. While this represents a positive decline from 18% 2 years ago, specific concerns in this area are detailed below.

We intervened in 22% of health board complaints that we closed – compared to 27% last year.

Performance specific to your organisation

During 2025-26, we received 230 complaints about your organisation and closed 216 complaints (some of which may have been carried over from the previous year).

We intervened in 18% of the complaints we closed about your organisation.

We made 86 new recommendations to your organisation in the cases closed this year.

There were 92 recommendations that fell due during this period. Your organisation complied with 71% of these within the agreed timescales.

Detailed data on the complaints we handled about your organisation in this period can be found in the appendices below.

Improving compliance with our recommendations

We always take time to ensure that recommendations and timescales are agreed with public bodies before finalising them. Therefore we expect agreed deadlines to be met. Timely compliance is not, however, as high as it should be; with only 69% of our recommendations across Wales complied with on time as at 31 March 2026. Promptly delivering agreements to resolve injustice or hardship for individuals, and implementing systemic learning on time, is vital to build and maintain public trust in both our office and your organisation.

We recognise that unexpected challenges arise that make deadlines difficult to meet. In response to feedback from public bodies, we have adapted our approach moving forward: if you request a reasonable extension on or before the original

deadline, and you meet that new date, it will be recorded as complied with on time. We hope this is a welcome adjustment that will help demonstrate a more accurate compliance rate over the coming years.

Supporting improvement of public services – key themes and our own initiative work

When an investigation reveals serious systemic risks that may affect many individuals, or offer wider sector lessons, we publish a public interest report. We published 9 such reports during this period, the vast majority concerning health boards. If you have not already done so, I encourage you to read these reports for their valuable insights - here.

Tragically, we have seen some instances of both individual shortcomings and wider systemic failures causing injustice to citizens in Wales. Key themes in this period have included: poor waiting list management (including inappropriate removal of patients from waiting lists); poor prescribing practice failures where we have seen communication and process breakdown between medical and pharmacy teams; and delays and clinical failures in urgent cancer referrals and ophthalmology.

We have also seen concerning complaint handling failures. Some health board complaint investigations have shown a lack of curiosity, objectivity and rigour which are essential to robust and thorough complaint investigation. In addition, we have seen failures to remain open and transparent with service users who have experienced harm, falling short of duty of candour requirements.

I strongly encourage all health boards and trusts to read the 5 public interest reports and recommendations issued during this period, and to use these insights to proactively strengthen your own complaint handling practices where appropriate.

We continue to expand the use of our own initiative powers. These allow us to investigate emerging issues proactively, addressing administrative failings before they multiply.

This year we issued a follow up report on public bodies' compliance with our previously published report on carers. You will recall I shared my original report with you given your role in identifying, assessing and supporting carers, especially during hospital discharge, and working collaboratively with others as part of an integrated system. Our follow up report can be found here.

Ongoing own initiative investigations

As at March 2026, we were conducting a further 4 own initiative investigations which focus, among other things, on:

- potential maladministration and service failure in health care

- how social landlords deal with complaints about disrepair and damp and mould.

We expect to complete this work later in 2026, and will determine then if the findings warrant publication in the public interest.

Our Complaints Standards Work

By the end of March 2026, all local authorities, health boards and 21 housing associations in Wales were operating under our model complaints policy. During 2025-26, we initiated the transition for the remaining housing associations and we expect them to be fully compliant by the end of September 2026.

Organisations that are already compliant, or will be shortly, account for 85% of new complaints about public services which we receive.

Our free complaint handling training remains highly requested; we delivered 58 sessions to public bodies across Wales this year, bringing our total since 2020 to over 600 sessions and 10,000 participants.

More broadly we expect to publish the data on complaints handled by local authorities in Wales during 2024-25 and 2025-26 in the Autumn.

Action we would like your organisation to take

To build on findings from this period, can I ask that your organisation takes the following actions:

- Present this Annual Letter and associated data to the Board at the next available opportunity and notify me of the planned meeting dates.

- Review the data in this letter, alongside your own data to better understand your performance, identify trends, and review your compliance with recommendations made by my office.

- Read the reports highlighted in this letter to extract relevant learning for your own Authority.

- Provide my office with a copy of your Annual Report for 2025-26 on the Duty of Candour and Quality.

- Inform me of the outcome of your considerations and proposed action plan at the earliest opportunity.

I would like to thank you, and your officers, for your continued openness and engagement with my office.

Yours sincerely

Michelle Morris
Public Services Ombudsman

Cc. chris.bown@wales.nhs.uk
psow.cardiffuhb@wales.nhs.uk

Information Sheet

Glossary of terms a guide to some of the terms used within our Annual Letters and Appendices.

Appendix A shows the number of complaints we received for all health boards in 2025-26. These complaints are contextualised by the population of each authority.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows intervention rates for all health boards in 2025-26. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Appendix D shows outcomes of the complaints we closed for the Health Board in 2025-26. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix E shows the compliance performance of each health board.

Annual Letters - Glossary of terms

Term	Definition
Complaints received	The number of duly made complaints we receive about a Public Body.
Duly made complaint	A complaint about public services is duly made when: • the organisation is within our jurisdiction and • the organisation has replied or had the opportunity to reply and • the events complained about happened less than a year ago, or the complainant became aware of them less than a year ago (unless there was a good reason the complainant could not complain sooner) and • the complainant is entitled to bring a complaint and • we have the details we need e.g. name, contact details, organisation being complained about, we can understand the complaint. A complaint about a local councillor is duly made when: • we have the details we need e.g. name and contact details of the complainant, the name of the councillor and the Local Authority they are a member of • we have a signed declaration from the complainant and any third parties whose evidence has been submitted.
Early Resolution	A matter which is closed without investigation because there is an obvious solution and the body agrees to carry out action to resolve the matter. The body must give us evidence that it has taken action within the timeframe agreed.
Intervention	Cases which we have closed and we have either: • Upheld the complaint after investigation. • Resolved the complaint by way of Voluntary Settlement. • Resolved the complaint by way of Early resolution.

Voluntary Settlement	A matter which has progressed to investigation stage but closed without the investigation being completed because we agree that action which the body has voluntarily suggested it will take is appropriate to resolve the matter. The body must give us evidence that it has taken action within the timeframe agreed.
Uphold	A matter we have closed after investigation and where we found that something went wrong.
% of interventions	The number of public service complaints we closed that involved Early Resolution/Voluntary Settlement and those which we upheld following an investigation, divided by the total number of duly made public service complaints we closed in the reporting period.
Upheld %	The proportion of the complaints in which we intervened that we upheld in the reporting period, shown as a percentage.
Cases Closed	The number of complaints we closed during the reporting period. This may be different from the number we received because there may be some complaints we received in the previous reporting period but which we closed in this reporting period.
Recommendation	These are actions which we ask bodies to take within agreed timescales when we find something has gone wrong. These may be actions to help the individual complainant or systemic actions to help improve services for all service users. We can make recommendations as part of an Early Resolution, Voluntary Settlement or when upholding a complaint following investigation. When we make recommendations, organisations must provide evidence to us that they have complied.
Recommendations made	The number of recommendations we made to bodies during the reporting period. (1 April 2025 to 31 March 2026)
Recommendations falling due	The number of recommendations which needed to be complied with within the reporting period (1 April 2025 to 31 March 2026). Some recommendations will have been made in the previous reporting period but fell due within this reporting period.

Recommendations complied with in line with agreed target date %	The number of recommendations which were complied with by the agreed timescale as set out in Early Resolution, Voluntary Settlement or Investigation report (applicable for those falling due in 2025-26).
Population	Population is included to provide context, based upon the size of an organisation. However, it is recognised that complaints can be made by people who are not included in the population figure, for example, residents from outside the health board or local authority area, or non-contract holders. • For **local authorities**, population refers to the estimated total number of people living in the local authority area. The figures are taken from the StatsWales.[1] • For **housing associations**, population refers to the total stock at social rent, shown in units. This includes general needs stock, sheltered stock, other supported stock and extra care stock with non self-contained bedsits, hostels and shared housing. This figure is taken from StatsWales.[2] • For **health boards**, population refers to the estimated total number of people living in the health board area. The figures are taken from StatsWales.[3]

[1] Population estimates by local authority, year, sex and age | StatsWales
[2] Social landlord housing stock, including social and non social housing | StatsWales
[3] Population estimates by local health boards, year, sex and age | StatsWales

Appendix A – Complaints received (overview)

Health Board	Complaints Received	Population	Received per 1,000 residents
Aneurin Bevan University Health Board	263	601,686	0.44
Betsi Cadwaladr University Health Board	283	697,115	0.41
Cardiff and Vale University Health Board	230	519,662	0.44
Cwm Taf Morgannwg University Health Board	173	449,346	0.39
Hywel Dda University Health Board	172	389,160	0.44
Powys Teaching Health Board	31	135,059	0.23
Swansea Bay University Health Board	199	394,553	0.50
Welsh Ambulance Services University NHS Trust	37	-	-
Total	**1388**	**3,186,581**	**0.44**

Appendix B – Complaints received (by organisation)

Cardiff and Vale University Health Board	Complaints Received	% share
Admissions/discharge and transfer procedures	4	2%
Adult Mental Health	16	7%
Ambulance Services	0	
Appointment procedures (including outpatients)	16	7%
Care Homes	0	
Child and Adolescent Mental Health	2	1%
Clinical treatment in hospital	120	52%
Clinical treatment outside hospital; Dentist	1	0%
Clinical treatment outside hospital; GP	0	
Clinical treatment outside hospital; Other	7	3%
Clinical treatment outside hospital; Physiotherapist	1	0%
Complaints Handling	0	
Confidentiality	0	
Continuing care	1	0%
De-Registration	0	
Disclosure of personal information / data loss	2	1%
Finance and Taxation	1	0%
Funding	3	1%
Gender Identity Funding	0	
Health	18	8%
Housing	0	
Independent Health Care providers	0	
Medical records/standards of record-keeping	3	1%
Medication; Prescription dispensing	2	1%
Non-medical services	0	
Nosocomial (Framework)	0	
Other	7	3%
Other miscellaneous	0	
Out of Hours GP care	1	0%
Patient list issues	11	5%
Poor/No communication or failure to provide information	0	
Prisoner Care	1	0%
Recruitment and appointment procedures	0	
Referral to treatment time	8	3%
Rudeness/inconsiderate behaviour/staff attitude	4	2%
Services for vulnerable adults (eg with learning difficulties. or with mental health issues)	1	0%
Various Other	0	
Whistle-blowing	0	
Total	**230**	

Appendix C – Cases with PSOW intervention (overview)

Health Board	No. of interventions	No. of closures	% of interventions
Aneurin Bevan University Health Board	64	254	25%
Betsi Cadwaladr University Health Board	57	272	21%
Cardiff and Vale University Health Board	38	216	18%
Cwm Taf Morgannwg University Health Board	32	172	19%
Hywel Dda University Health Board	43	160	27%
Powys Teaching Health Board	7	28	25%
Swansea Bay University Health Board	49	195	25%
Welsh Ambulance Services University NHS Trust	8	36	22%
Total	**298**	**1333**	**22%**

Appendix D – Complaint outcomes (by organisation)

Cardiff and Vale University Health Board		% Share
Complaint investigation discontinued (with early resolution at assessment stages)	0	
Complaint investigation discontinued (without settlement)	0	
Decision not to investigate complaint	98	45%
Early resolution	33	15%
Matter out of jurisdiction	49	23%
Non-public interest report issued: complaint not upheld	2	1%
Non-public interest report issued: complaint not upheld with early resolution at assessment stage	0	
Non-public interest report issued: complaint upheld	5	2%
Non-public interest report issued: complaint upheld with early resolution at assessment stage	0	
Premature	29	13%
Public interest report issued: complaint upheld	0	
Public Interest report issued: complaint upheld with early resolution at assessment stage	0	
Special Interest Report	0	
Voluntary settlement	0	
Total	**216**	

Appendix E – Compliance performance comparison

Health Board	Number of recommendations made on complaints closed in 2025-26	Number of recommendations falling due in 2025-26	% of recommendations, complied with in line with agreed target date
Aneurin Bevan University Health Board	175	142	70%
Betsi Cadwaladr University Health Board	157	137	61%
Cardiff and Vale University Health Board	86	92	71%
Cwm Taf Morgannwg University Health Board	94	93	72%
Hywel Dda University Health Board	118	118	81%
Powys Teaching Health Board	9	10	70%
Swansea Bay University Health Board	143	144	60%
Welsh Ambulance Services University NHS Trust	23	36	83%

Ombwdsmon
Ombudsman
Cymru · Wales

Gofynnwch am: Safonau Cwynion
01656 641150
Caseinfo@ombwdsmon.cymru

Dyddiad: 17 Medi 2026

Kirsty Williams
Cadeirydd
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Drwy ebost yn unig
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Annwyl Kirsty

Llythyr Blynyddol 2025-26

Ein Rôl

Fel Ombwdsmon Gwasanaethau Cyhoeddus Cymru, rydym yn ystyried cwynion am wasanaethau cyhoeddus yn annibynnol, ac yn ymchwilio i honiadau o dorri Cod Ymddygiad cynghorwyr. Rydym hefyd yn gosod safonau ar gyfer trin cwynion ar gyfer cyrff cyhoeddus, yn ysgogi dysgu parhaus o gwynion ac yn cynnal ymchwiliadau i wasanaethau cyhoeddus ar ein liwt ein hunain.

Pwrpas y Llythyr Blynyddol hwn

Mae'r llythyr hwn yn darparu diweddariad ar ein gwaith am y cyfnod yma, ac yn tynnu sylw at dueddiadau allweddol yng nghwynion am Fyrddau Iechyd Cymru a'r gwasanaethau cyhoeddus. Mae'n manylu ar berfformiad sy'n benodol i'ch sefydliad ac yn amlinellu'r camau gweithredu cadarnhaol yr hoffem i'ch sefydliad eu cymryd.

Trosolwg – blwyddyn o dorri recordiau

Mae'r llythyr hwn, fel bob un, yn cydfynd â'n cyhoeddiad o'r Adroddiad Blynyddol sydd ag arwyddocâd arbennig y flwyddyn hon wrth i ni nodi ein 20fed penblwydd. Gwnaethom gau ein blwyddyn prysuraf erioed wrth i'r swyddfa dderbyn 4,507 o gwynion dilys ar draws ei chylchoedd gwasanaethau cyhoeddus a Chod Ymddygiad - 27% yn fwy na llynedd, 47% yn fwy na 3 mlynedd yn ôl, a 3 gwaith cymaint ag 20 mlynedd yn ôl.

I gwrdd â'r galw hyn, gwnaethom gau nifer record o gwynion, 29% yn fwy na'r llynedd a 43% yn fwy o gymharu â 3 mlynedd yn ôl. Gwnaethom ymyrryd mewn 568 o gwynion a gaewyd.

Mae dod o hyd i ddatrysiad cyflym i gwynion, lle bo modd, yn parhau i fod yn bwysig i ni ac yn fuddiol i bob parti dan sylw. Eleni, roedd 85% o'n hymyriadau'n cynnwys elfen o Ddatrysiad Cynnar, proses rydyn ni'n gobeithio sydd wedi adlewyrchu'n werthfawr i'ch sefydliad ac i achwynwyr.

Er gwaethaf cynnydd yn y nifer o achosion, parhaodd ein hamseroedd trin achosion i fod yn effeithlon. Cwblhawyd asesiadau cychwynnol a Datrysiadau Cynnar o fewn 4 wythnos – ymhell o flaen ein targed o 6 wythnos. Yn ogystal, gwnaethom gynnal tuedd i lawr ar ein hamser ymchwilio cyfartalog o 54 wythnos eleni i lawr o 64 wythnos yn ystod 2023-24.

Trosolwg o gwynion Byrddau Iechyd

Yn ystod 2025-26, cawsom 1,351 o gwynion am fyrddau iechyd gan wneud cynnydd sylweddol o 42% o'r flwyddyn gynt. Triniaeth glinigol mewn ysbytai sy'n parhau fel y pryder mwyaf cyffredin. Yn ogystal, roedd ymdrin â chwynion yn cyfrif am tua 14% o gwynion. Er bod hyn yn cynrychioli gostyngiad cadarnhaol o 18% 2 flynedd yn ôl, manylir ar bryderon penodol yn y maes hwn isod.

Gwnaethom ymyrryd mewn 22% o gwynion am fyrddau iechyd a gaewyd – o'i gymharu â 27% y llynedd.

Perfformiad sy'n benodol i'ch sefydliad

Yn ystod 2025-26, cawsom 230 o gwynion am eich sefydliad a gwnaethom gau 216 o gwynion (gall rhai ohonynt fod wedi eu cario o'r flwyddyn flaenorol).

Gwnaethom ymyrryd mewn 18% o'r cwynion a gaewyd am eich sefydliad.

Gwnaethom 86 o argymhellion i'ch sefydliad yn yr achosion a gaewyd eleni.

Roedd yna 92 o argymhellion a oedd yn ddyledus yn ystod y cyfnod hwn. Cyflawnwyd 71% o argymhellion oedd angen eu cwblhau o fewn yr amserlen y cytunwyd arni.

Gallwch ddod o hyd i wybodaeth fanwl am gwynion am eich sefydliad a gafodd eu hymchwilio gennym eleni yn yr Atodiadau isod.

Gwella cydymffurfiaeth â'n hargymhellion

Rydyn ni bob tro'n cymryd ein hamser i sicrhau bod ein hargymhellion a'n hamserlenni'n cael ei gytuno gan gyrff cyhoeddus cyn eu cwblhau. Felly, rydym yn disgwyl i'r terfynau amser y cytunwyd arnynt gael eu cyrraedd. Fodd bynnag, nid yw cydymffurfiaeth amserol mor uchel ag y dylai fod; a dim ond 69% o'n hargymhellion ledled Cymru y cydymffurfiwyd â nhw ar amser ar 31 Mawrth 2026. Mae cyflawni cytundebau'n brydlon i ddatrys anghyfiawnder neu galedi i unigolion a gweithredu dysgu systematig ar amser yn hanfodol i feithrin a chynnal ymddiriedaeth y cyhoedd yn ein swyddfa ac yn eich sefydliadau.
Rydym yn cydnabod bod heriau annisgwyl yn gallu codi sy'n gwneud hi'n anodd cwrdd â therfynau amser. Mewn ymateb i adborth gan gyrff cyhoeddus, rydym

wedi addasu ein dull wrth symud ymlaen; os ydych yn gofyn am estyniad rhesymol ar neu gyn y dyddiad cau, ac rydych yn cwrdd â'r dyddiad newydd hwnnw, bydd yn cael ei gofnodi fel un sydd wedi'i gydymffurfio mewn pryd. Gobeithiwn fod hwn yn addasiad sydd wedi ei groesawu a fydd yn helpu i arddangos mwy o gyfraddau cydymffurfio cadarnhaol dros y blynyddoedd sydd i ddod.

Cefnogi gwelliant gwasanaethau cyhoeddus – themâu allweddol a'n gwaith ar ei liwt ei hun

Pan fydd ymchwiliad yn datgelu risgiau systematig difrifol sy'n gallu effeithio ar nifer o unigolion, neu'n rhoi gwersi i'r sector ehangach, rydym yn cyhoeddi adrodd er budd y cyhoedd. Cyhoeddom 9 adroddiad er budd y cyhoedd yn ystod y cyfnod hwn, gyda'r mwyafrif helaeth yn ymwneud â'r Byrddau Iechyd. Os nad ydych yn barod wedi gwneud, rwy'n eich annog i ddarllen yr adroddiadau hyn i gael eu mewnwelediadau gwerthfawr - yma.

Yn drasig, rydym wedi gweld rhai achosion o ddiffygion unigol a methiannau systematig ehangach gan achosi anghyfiawnder i ddinasyddion yng Nghymru. Mae themâu allweddol yn ystod y cyfnod yma wedi cynnwys: rheolaeth wael o restrau aros (gan gynnwys tynnu cleifion oddi ar restrau aros yn amhriodol); methiannau gwael mewn arferion rhagnodi lle gwelsom fethiant mewn cyfathrebu a phrosesau rhwng timau meddygol a fferyllol; ac oediadau a methiannau clinigol mewn atgyfeiriadau canser brys ac offthalmoleg.

Rydym hefyd wedi gweld methiannau sy'n peri pryder wrth ymdrin â chwynion. Mae rhai ymchwiliadau i gwynion am Fyrddau Iechyd yn dangos diffyg chwilfrydedd, gwrthrychedd a thrylwyredd, sy'n hanfodol ar gyfer ymchwiliad cadarn a thrylwyr i gwynion. Yn ogystal, rydym wedi gweld methiannau sy'n parhau i fod yn agored a thryloyw gyda defnyddwyr gwasanaeth sydd wedi profi niwed, a methu â chyflawni gofynion didwylledd.

Rwy'n annog yn gryf bob Bwrdd Iechyd ac Ymddiriedolaeth i ddarllen y 5 adroddiad a'r argymhellion budd y cyhoedd a gyhoeddwyd yn ystod y cyfnod hwn, ac i ddefnyddio'r mewnwelediadau hyn i gryfhau eich arferion trin cwynion eich hun yn rhagweithiol lle bo'n briodol.

Rydym yn parhau i ehangu defnydd ein pwerau ei liwt ei hun. Mae'r rhain yn ein galluogi i ymchwilio i faterion sy'n codi yn rhagweithiol, gan fynd i'r afael â methiannau gweinyddol cyn iddynt gynyddu.

Eleni gwnaethom gyhoeddi adroddiad dilynol ar gydymffurfiaeth cyrff cyhoeddus â'n hadroddiad wnaethom gyhoeddi'n flaenorol ar ofalwyr. Fe gofiwch i mi rannu fy adroddiad gwreiddiol gyda chi o ystyried eich rôl wrth nodi, asesu a chefnogi gofalwyr, yn enwedig yn ystod rhyddhau o'r ysbyty, a gweithio ar y cyd ag eraill fel rhan o system integredig. Gellir dod o hyd i'n hadroddiad dilynol yma.

Ymchwiliadau parhaus ar ei liwt ei hun

Ym mis Mawrth 2026, roeddem yn cynnal 4 ymchwiliad pellach ar ei liwt ei hun a oedd yn canolbwyntio, ymhlith pethau eraill, ar:

- camweinyddu posibl a methiant gwasanaeth mewn gofal iechyd

- sut mae landlordiaid cymdeithasol yn delio â chwynion am ddiffyg atgyweirio a lleithder a llwydni.

Rydym yn disgwyl cwblhau'r gwaith hwn yn hwyrach yn 2026, a byddwn yn penderfynu bryd hynny a yw'r canfyddiadau'n cyfiawnhau cyhoeddi er budd y cyhoedd.

Ein gwaith Safonau Cwynion

Erbyn diwedd mis Mawrth 2026, roedd pob awdurdod lleol, byrddau iechyd a 21 o gymdeithasau tai yng Nghymru yn gweithredu o dan ein polisi cwynion enghreifftiol. Yn ystod 2025-26, fe gychwynnom y broses bontio ar gyfer y cymdeithasau tai sy'n weddill ac rydym yn disgwyl iddynt gydymffurfio'n llawn erbyn diwedd mis Medi 2026.

Mae sefydliadau sydd eisoes yn cydymffurfio, neu a fydd yn fuan, yn cyfrif am 85% o gwynion newydd am wasanaethau cyhoeddus a dderbyniwn.

Mae ein hyfforddiant trin cwynion sydd am ddim yn parhau i fod yn boblogaidd iawn; ac rydym wedi darparu 58 sesiwn arall i gyrff cyhoeddus ledled Cymru eleni gan ddod â'n cyfanswm ers 2020 i 600 sesiwn a 10,000 o gyfranogwyr.

Yn ehanghach, rydym yn disgwyl i gyhoeddi'r data ar gwynion a gafodd eu trin gan gymdeithasau tai yng Nghymru yn ystod 2024-25 a 2025-26 yn yr Hydref.

Camau yr hoffem i'ch sefydliad eu cymryd

Er mwyn adeiladu ar ganfyddiadau o'r cyfnod hwn rwy'n gofyn bod eich sefydliad yn cymryd y camau gweithredu canlynol:

- Cyflwyno'r Llythyr Blynyddol hwn i'r Bwrdd Llywodraethu neu'r Pwyllgor Archwilio ar y cyfle cynharaf ac i roi gwybod i mi am unrhyw ddyddiadau cyfarfodydd a gynlluniwyd.

- Adolygu'r data yn y llythyr hwn ynghyd â'ch data eich hun, er mwyn deall perfformiad eich cwynion yn well, i adnabod tueddiadau ac i adolygu'ch cydymffurfiad â'r argymhellion a wnaed gan fy swyddfa.

- Darllen yr adroddiadau a amlygwyd yn y llythyr hwn i dynnu gwersi perthnasol i'ch Cymdeithas eich hun.

- Darparu copi o'ch Adroddiad Blynyddol ar gyfer 2025-26 ar Ddyletswydd Gonestrwydd ac Ansawdd i'm swyddfa.
- Rhoi gwybod i mi am ganlyniad eich ystyriaethau a'ch cynllun gweithredu arfaethedig ar y cyfle cyntaf.

Hoffwn ddiolch i chi, a'ch swyddogion, am eich agoredrwydd parhaus a'ch ymgysylltiad â'm swyddfa.

Yn gywir

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Ombwsdmon Gwasanaethau Cyhoeddus

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Taflen Wybodaeth

Gerifa o dermau - canllaw i rai o'r termau a ddefnyddir yn ein Llythyrau Blynyddol a'n Atodiadau.

Mae **Atodiad A** yn dangos nifer y cwynion a dderbyniom am y byrddau iechyd i gyd yn 2025-26. Mae'r cwynion hyn wedi'u roi mewn cyd-destun gan boblogaeth pob awdurdod.

Mae **Atodiad B** yn dangos categoreiddio pob cwyn a dderbyniwyd, a pha gyfran o'r cwynion a dderbyniwyd sy'n cynrychioli'r Bwrdd Iechyd.

Mae **Atodiad C** yn dangos cyfraddau ymyrraeth ar gyfer pob bwrdd iechyd yn 2025-26. Caiff ymyrraeth ei chategoreiddio naill ai yn ôl cwyn a gadarnhawyd (naill ai er budd y cyhoedd neu nad yw er budd y cyhoedd), datrysiad cynnar, neu setliad gwirfoddol.

Mae **Atodiad D** yn dangos canlyniadau'r cwynion a gaewyd gennym ar gyfer y Bwrdd Iechyd yn 2025-26. Mae'r tabl hwn yn dangos y cyfaint a'r gyfran y mae pob canlyniad yn ei chynrychioli ar gyfer y Bwrdd Iechyd.

Mae **Atodiad E** hyn yn dangos perfformiad cydymffurfio pob bwrdd iechyd.

Llythyrau Blynyddol - Geirfa o dermau

Term	Diffiniad
Cwynion a gafwyd	Nifer y cwynion a wnaed yn briodol a dderbyniwn am Gorff Cyhoeddus.
Cwyn a wnaed yn briodol	Gwneir cwyn am wasanaethau cyhoeddus yn briodol pan: • mae'r sefydliad o fewn ein hawdurdodaeth a • mae'r sefydliad wedi ymateb neu wedi cael cyfle i ymateb a • mae'r digwyddiadau y cwynwyd amdanynt wedi cymryd lle llai na blwyddyn yn ôl, neu daeth yr achwynydd yn ymwybodol ohonynt lai na blwyddyn yn ôl (oni bai bod rheswm da pam na allai'r achwynydd gwyno'n gynt) a • mae gan yr achwynydd hawl i gyflwyno cwyn a • mae gennym y manylion sydd eu hangen arnom e.e. enw, manylion cyswllt, y sefydliad y cwynir amdano, gallwn ddeall y gŵyn. Gwneir cwyn am gynghorydd lleol yn briodol pan: • mae gennym y manylion sydd eu hangen arnom e.e. enw a manylion cyswllt yr achwynydd, enw'r cynghorydd a'r Awdurdod Lleol y maent yn aelod ohono • mae gennym ddatganiad wedi'i lofnodi gan yr achwynydd ac unrhyw drydydd partïon y mae eu tystiolaeth wedi'i chyflwyno.
Datrysiad Cynnar	Mater sy'n cael ei gau heb ymchwiliad oherwydd bod ateb amlwg a bod y corff yn cytuno i gymryd camau i ddatrys y mater. Rhaid i'r corff roi tystiolaeth i ni ei fod wedi cymryd camau o fewn yr amserlen y cytunwyd arni.
Ymyriad	Achosion a gaewyd gennym ac rydym naill ai wedi: • Cadarnhau'r gŵyn ar ôl ymchwiliad. • Datrys y gŵyn drwy Setliad Gwirfoddol. • Datryswyd y gŵyn drwy Ddatrysiad Cynnar.
Setliad Gwirfoddol	Mater sydd wedi symud ymlaen i'r cam ymchwilio ond a gaewyd heb i'r ymchwiliad gael ei gwblhau oherwydd ein bod ni'n cytuno bod y camau y mae'r corff wedi awgrymu'n wirfoddol y bydd yn eu cymryd yn briodol i ddatrys y mater. Rhaid i'r corff roi tystiolaeth i ni

	ei fod wedi cymryd camau o fewn yr amserlen y cytunwyd arni.
Cadarnhau	Mater a gaewyd gennym ar ôl ymchwiliad a lle rydym wedi canfod bod rhywbeth wedi mynd o'i le.
% o ymyriadau	Nifer y cwynion gwasanaeth cyhoeddus a gaewyd gennym a oedd yn cynnwys Datrysiad Cynnar/Setliad Gwirfoddol a'r rhai a gadarnhawyd gennym yn dilyn ymchwiliad, wedi'i rannu â chyfanswm nifer y cwynion gwasanaeth cyhoeddus a wnaed yn briodol a gaewyd gennym yn ystod y cyfnod adrodd.
% a gadarnhawyd	Y gyfran o'r cwynion y gwnaethom ymyrryd ynddynt a gadarnhawyd gennym yn ystod y cyfnod adrodd, a ddangosir fel canran.
Achosion wedi'u cau	Nifer y cwynion a gaewyd gennym yn ystod y cyfnod adrodd. Gall hyn fod yn wahanol i'r nifer a dderbyniwyd gennym oherwydd efallai bod rhai cwynion a dderbyniwyd gennym yn y cyfnod adrodd blaenorol ond a gaewyd gennym yn y cyfnod adrodd hwn.
Argymhelliad	Dyma gamau gweithredu rydym yn gofyn i gyrff eu cymryd o fewn amserlenni y cytunwyd arnynt pan fyddwn yn canfod bod rhywbeth wedi mynd o'i le. Gall y rhain fod yn gamau gweithredu i helpu'r achwynydd unigol neu'n gamau gweithredu systemig i helpu i wella gwasanaethau i bob defnyddiwr gwasanaeth. Gallwn wneud argymhellion fel rhan o Ddatrysiad Cynnar, Setliad Gwirfoddol neu wrth gadarnhau cwyn yn dilyn ymchwiliad. Pan fyddwn yn gwneud argymhellion, rhaid i sefydliadau ddarparu tystiolaeth i ni eu bod wedi cydymffurfio.
Argymhellion a wnaed	Nifer yr argymhellion a wnaethom i gyrff yn ystod y cyfnod adrodd. (1 Ebrill 2025 i 31 Mawrth 2026)
Argymhellion sy'n dod i ben	Nifer yr argymhellion yr oedd angen cydymffurfio â nhw o fewn y cyfnod adrodd (1 Ebrill 2025 i 31 Mawrth 2026). Bydd rhai argymhellion wedi'u gwneud yn y cyfnod adrodd blaenorol ond roeddent yn ddyledus o fewn y cyfnod adrodd hwn.
Cydymffurfiwyd â'r argymhellion yn unol â'r dyddiad	Nifer yr argymhellion y cydymffurfiwyd â nhw erbyn yr amserlen y cytunwyd arni fel y nodir yn yr adroddiad

targed y cytunwyd arno %	Datrysiad Cynnar, Setliad Gwirfoddol neu Ymchwiliad (yn berthnasol i'r rhai sy'n ddyledus yn 2025-26).
Poblogaeth	Mae poblogaeth wedi'i gynnwys i roi cyd-destun, yn seiliedig ar faint sefydliad. Fodd bynnag, cydnabyddir y gall pobl nad ydynt wedi'u cynnwys yn y ffigur poblogaeth wneud cwynion, er enghraifft, trigolion o'r tu allan i ardal y bwrdd iechyd neu'r awdurdod lleol, neu bobl nad ydynt yn ddeiliaid contract. • Ar gyfer **awdurdodau lleol** , mae poblogaeth yn cyfeirio at gyfanswm amcangyfrifedig y bobl sy'n byw yn ardal yr awdurdod lleol. Mae'r ffigurau wedi'u cymryd o StatsCymru.[1] • Ar gyfer **cymdeithasau tai**, mae poblogaeth yn cyfeirio at gyfanswm y stoc ar rent cymdeithasol, a ddangosir mewn unedau. Mae hyn yn cynnwys stoc anghenion cyffredinol, stoc gwarchodedig, stoc â chymorth arall a stoc gofal ychwanegol gyda lletyau un ystafell nad ydynt yn hunangynhwysol, hosteli a thai a rennir. Mae'r ffigur hwn wedi'i gymryd o StatsCymru.[2] • Ar gyfer **byrddau iechyd** , mae poblogaeth yn cyfeirio at gyfanswm amcangyfrifedig y bobl sy'n byw yn ardal y bwrdd iechyd. Mae'r ffigurau wedi'u cymryd o StatsCymru.[3]

[1] Amcangyfrifon poblogaeth yn ôl awdurdod lleol, blwyddyn, rhyw ac oedran | StatsCymru
[2] Stoc tai landlordiaid cymdeithasol, gan gynnwys tai cymdeithasol a thai nad sy'n rhai cymdeithasol …
[3] Amcangyfrifon poblogaeth yn ôl bwrdd iechyd lleol, blwyddyn, rhyw ac oedran | StatsCymru

Atodiad A – Cwynion a dderbyniwyd (trosolwg)

Bwrdd Iechyd	Cywnion a Gafwyd	Poblogaeth	Derbyniwyd fesul 1000 o drigolion
Bwrdd Iechyd Prifysgol Aneurin Bevan	263	601686	0.44
Bwrdd Iechyd Prifysgol Betsi Cadwaladr	283	697115	0.41
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro	230	519662	0.44
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	173	449346	0.39
Bwrdd Iechyd Prifysgol Hywel Dda	172	389160	0.44
Bwrdd Iechyd Addysgu Powys	31	135059	0.23
Bwrdd Iechyd Prifysgol Bae Abertawe	199	394553	0.50
Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru	37	-	-
Cyfanswm	**1388**	**3186581**	**0.44**

Atodiad B – Cwynion a dderbyniwyd (yn ôl sefydliad)

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro	Cwynion a Gafwyd	% rhannu
Gweithdrefnau derbyn/rhyddhau a throsglwyddo	4	2%
Iechyd Meddwl Oedolion	16	7%
Gwasanaethau Ambiwlans	0	
Gweithdrefnau apwyntiad (gan gynnwys cleifion allanol)	16	7%
Cartrefi gofal	0	
Iechyd Meddwl Plant a Phobl Ifanc	2	1%
Triniaeth glinigol mewn ysbyty	120	52%
Triniaeth glinigol y tu allan i ysbyty; Deintydd	1	0%
Triniaeth glinigol y tu allan i ysbyty; Meddyg Teulu	0	
Triniaeth glinigol y tu allan i ysbyty; Eraill	7	3%
Triniaeth glinigol y tu allan i ysbyty; Ffisiotherapydd	1	0%
Ymdrin â chwynion	0	
Cyfrinachedd	0	
Gofal Parhaus	1	0%
Dadgofrestriad	0	
Datgelu gwybodaeth bersonol / colli data	2	1%
Cyllid a Threthiant	1	0%
Ariannu	3	1%
Cyllid Hunaniaeth Rhywedd	0	
Iechyd	18	8%
Tai	0	
Darparwr Gofal Annibynnol	0	
Cofnodion Meddygol/Safonau cadw cofnodion	3	1%
Meddyginiaeth > Dosbarthu presgripsiynau	2	1%
Gwasanaethau anfeddygol	0	
Dim tystiolaeth o galedi neu anghyfiawnder	0	
Eraill	7	3%
Eraill Amrywiol	0	
Gofal Meddyg Teulu y Tu Allan i Oriau	1	0%
Materion rhestr glaf	11	5%
Cyfathrebu gwael/ Dim cyfathrebu neu fethiant i ddarparu gwybodaeth	0	
Gofal Carcharorion	1	0%
Gweithdrefnau recriwtio ac apwyntio	0	
Amser rhwng atgyfeirio a thriniaeth	8	3%
Anfoesgarwch/ ymddygiad anystyriol/ agwedd staff	4	2%
Gwasanaethau i oedolion Agored i Niwed (ee gydag anawsterau dysgu. neu â materion iechyd meddwl)	1	0%
Amrywiol Eraill	0	
Chwythu'r Chwiban	0	
Cyfanswm	**230**	

Atodiad C – Achosion lle ymyrrodd OGCC (trosolwg)

Bwrdd Iechyd	Nifer yr ymyriadau	Nifer y cwynion a gaewyd	% o ymyriadau
Bwrdd Iechyd Prifysgol Aneurin Bevan	64	254	25%
Bwrdd Iechyd Prifysgol Betsi Cadwaladr	57	272	21%
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro	38	216	18%
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	32	172	19%
Bwrdd Iechyd Prifysgol Hywel Dda	43	160	27%
Bwrdd Iechyd Addysgu Powys	7	28	25%
Bwrdd Iechyd Prifysgol Bae Abertawe	49	195	25%
Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru	8	36	22%
Cyfanswm	**298**	**1333**	**22%**

Atodiad D – Canlyniadau cwynion (yn ôl sefydliad)

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro		**% rhannu**
Rhoddwyd gorau i'r ymchwiliad i'r gŵyn (gyda datrysiad cynnar yn ystod y camau asesu)	0	
Rhoddwyd y gorau i ymchwilio'r gŵyn (heb setliad)	0	
Penderfynu peidio ymchwilio cwyn	98	45%
Datrys yn gynnar	33	15%
Mater tu hwnt i awdurdodaeth	49	23%
Adroddiad nid er budd y cyhoedd wedi'i gyhoeddi: y gŵyn heb ei chadarnhau	2	1%
Adroddiad nid er budd y cyhoedd wedi'i gyhoeddi: y gŵyn heb ei chadarnhau gyda datrysiad cynnar yn ystod y cam asesu	0	
Adroddiad nid er budd y cyhoedd wedi'i gyhoeddi: y gŵyn wedi'i chadarnhau	5	2%
Adroddiad nad yw er budd y cyhoedd wedi'i gyhoeddi: y gŵyn wedi'i chadarnhau a'i datrys yn gynnar yn y cam asesu	0	
Cynamserol	29	13%
Adroddiad Budd y Cyhoedd wedi'i gyhoeddi: y gŵyn wedi ei chadarnhau	0	
Adroddiad Budd y Cyhoedd wedi'i gyhoeddi: y gŵyn wedi'i chadarnhau gyda datrysiad cynnar yn ystod y cam asesu	0	
Adroddiad Budd Arbennig	0	
Setliadau gwirfoddol	0	
Cyfanswm	**216**	

Atodiad E – Cymhariaeth perfformiad cydymffurfio

Bwrdd Iechyd	Nifer yr amgymhellion a wnaed ar gwynion y caewyd yn 2025-26	Nifer yr amgymhellion sy'n ddyledus yn 2025-26	% yr argymhellion, y cydymffurfiwyd â dyddiad targed cytûn
Bwrdd Iechyd Prifysgol Aneurin Bevan	175	142	70%
Bwrdd Iechyd Prifysgol Betsi Cadwaladr	157	137	61%
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro	86	92	71%
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	94	93	72%
Bwrdd Iechyd Prifysgol Hywel Dda	118	118	81%
Bwrdd Iechyd Addysgu Powys	9	10	70%
Bwrdd Iechyd Prifysgol Bae Abertawe	143	144	60%
Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru	23	36	83%

Report Title:	Duty of Candour Annual Report 2025/26: Application of the Process, Themes, Trends and Staff Survey Findings		Agenda Item No:		7.5
Meeting:	Quality Committee	Public	X		27.10.2026
		Private			
Lead Executive Title:	Executive Nurse Director				
Report Author/s Title:	Assistant Director of Patient Experience				

Report Focus Summary – **AAA Framework:**

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

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

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

The annual report provides partial assurance that a functioning statutory Duty of Candour process is in place and that recurring risks are being identified.

Of 216 records reviewed, 178 (82.4%) were closed. The report also identifies gaps in timeliness, documentation, staff confidence, access to guidance and the effective sharing of learning. Further assurance is required that improvement actions are implemented, sustained and evaluated.

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

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

Recommendations

The Committee is asked to:

a. *Receive the report for assurance and endorse the recommendations to improve the process and assurance (below).*

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

This cover report introduces the Health Board's Duty of Candour Annual Report for 1 April 2025 to 31 March 2026.

The report provides an integrated assessment of case activity, statutory process performance, recurring themes and staff feedback.

Current position
The analysis covers 216 records. Of these, 178 (82.4%) were closed, 12 were in management review, 13 were under investigation and 13 were awaiting closure.

The principal themes relate to referral, follow-up and surveillance delays; diagnostic result and recognition failures; peri-operative and procedural care; deterioration and escalation; pressure damage; medication management; and falls.

Assurance
The overall assessment is partial assurance. There is evidence that the statutory process is operating, supported by substantial case identification and recorded closure. However, written notification within five working days, final responses, incomplete fields and missing supporting records reduce the level of assurance.

Staff survey findings also identify gaps in training, confidence in open and honest conversations, access to guidance and the effective sharing of learning. Improvement and oversight

The report proposes strengthened incident management, harm assessment, training and practical support, monthly exception reporting, consistent dissemination of learning, early identification of Duty of Candour cases and an ongoing documentation and audit programme. Clinical Boards should evidence implementation and sustained impact through their quality governance arrangements, supported by organisational oversight through the Quality Management System and reporting to the Quality Committee.

Recommendations to Improve the process and assurance

- **Incident management:** Clinical Boards commit to reducing incident backlogs and ensure cases progress promptly through review, investigation and closure.
- **Initial harm assessment:** Train incident reporters to assess and record the initial level of harm accurately and consistently.
- **Training and support:** Develop a revised Duty of Candour offer that includes refresher training, case-based learning, practical conversation skills and accessible central guidance.
- **Exception reporting:** Issue a monthly report covering overdue notifications, written correspondence and final responses, together with incomplete harm assessments and cases awaiting sign-off or redress consideration.
- **Learning and improvement:** Clinical Boards are required to evidence that learning actions have been implemented, sustained and achieved measurable improvement, with particular focus on pressure damage, deteriorating patients, medicines safety and falls.
- **Develop Templates-** These have been developed and disseminated

Early identification: Ensure the Duty of Candour is considered independently of whether a complaint has been made and without waiting for the full investigation to conclude.
Documentation and audit: Establish an ongoing audit Programme to confirm that supporting documentation is uploaded to the central system and that compliance can be monitored and verified.

Conclusion
The annual report provides assurance that the Health Board has established a functioning Duty of Candour process and is identifying recurring organisational risks. The limitations identified mean that assurance remains partial until improvements in timeliness, documentation, staff capability and measurable learning are demonstrated.

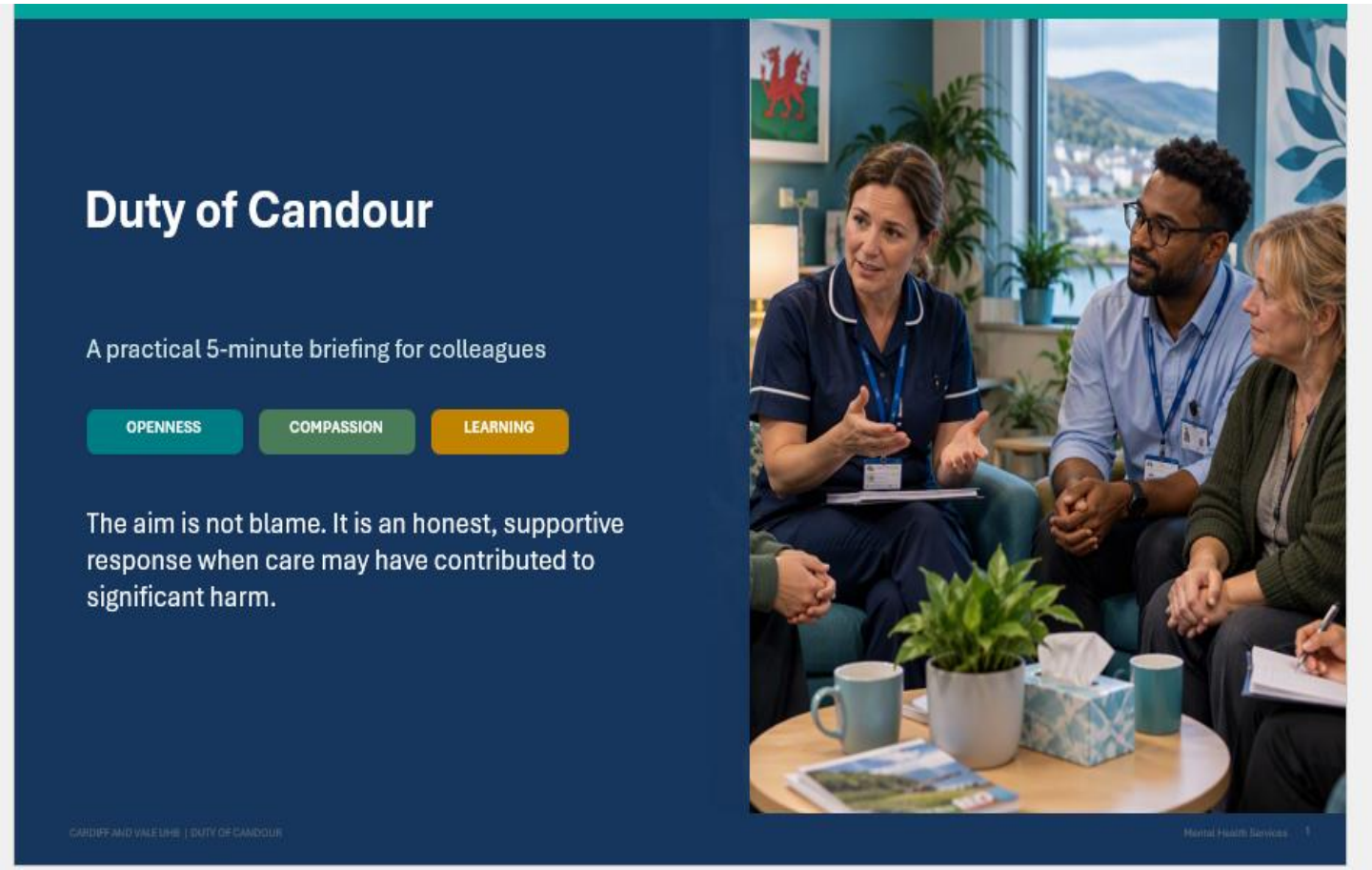
Appendices:

- Appendix 1 – Duty of Candour Annual Report 2025/26

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 report identifies compliance, quality and organisational learning risks. Mitigations are set out through the recommended improvement, audit, exception-reporting and governance actions.
Safety: Yes
The findings concern recurrent patient-safety themes, including delayed follow-up, diagnostic results, deterioration, pressure damage, medication safety and falls. Sustained oversight and measurable improvement are required.
Financial: Yes
Failure to implement Duty of Candour can result in an increase in same type of litigation cases and missed opportunities to utilize the redress scheme and embed learning.
Workforce: Yes
Delivery requires trained and confident staff, protected time, accessible specialist advice, supportive management and appropriate emotional support for staff involved in Duty of Candour processes.
Legal: Yes
The report concerns compliance with the statutory Duty of Candour. The annual report identifies areas where further assurance is required on adherence to process requirements and supporting documentation.
***Reputational**: Yes*
Failure to meet statutory requirements or demonstrate learning may affect public confidence and create regulatory and reputational risk. The recommended actions are intended to strengthen assurance.
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
The paper reports on assurance and does not propose a strategic service change. Communication should nevertheless remain accessible and responsive to individual circumstances.
Equality & Health: Yes
Duty of Candour communication should consider language, accessibility, capacity, consent and the identification of an appropriate representative. No separate service redesign requiring an EHIA is proposed in this paper.
Decarbonisation: Please select
No direct decarbonisation implications have been identified. The report does not propose changes that would materially affect carbon emissions.
Welsh Language: Yes
Communication must be available in Welsh and should reflect individual language preference and accessibility needs. Recommendations should be implemented in accordance with Welsh Language Standards and More than just words.



Duty of Candour: Annual Report Themes, Trends and Staff Survey Findings

Annual Report 2025-2026

Cardiff and Vale UHB)

QUALITY, SAFETY AND EXPERIENCE

Duty of Candour Annual Report 2025/26: Application of the Process, Themes, Trends and Staff Survey Findings

Report

Meeting	Quality Committee
Report status	For noting and endorsement of the recommendations
Reporting scope	216 Incident records, detailed case extract and 2026 staff survey
Executive lead	Executive Nurse Director
Author	Assistant Director of Patient Experience
Assurance rating	Partial assurance

Prepared from the Datix Duty of Candour export and the Duty of Candour staff feedback survey conducted 6 May to 17 June 2026.

The Duty of Candour Process in Wales

The Statutory Duty of Candour came into force across NHS Wales on 1 April 2023 under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and the Duty of Candour Procedure (Wales) Regulations 2023. It is an Organisational duty placed on NHS bodies. The procedure applies where a service user has experienced, or could experience, unexpected or unintended moderate or severe harm, or death, and the healthcare provided was or may have been a factor.

The procedure is intended to ensure that the organisation responds openly, compassionately and consistently when the threshold is met. It operates alongside the NHS Wales Listening to People formally Putting Things Right arrangements. It does not depend on a patient or family first making a complaint, and consideration of the duty should not wait until a full investigation has concluded.

Stage	Required Organisational response
1. Recognition and assessment	Identify the adverse outcome, consider the actual or potential level of harm and determine whether healthcare was or may have been a factor. Record the decision and rationale.
2. In-person notification	Notify the service user, or a person acting on their behalf, as soon as possible. In-person communication may be face to face, by telephone or by video call.
3. Apology, explanation and support	Offer a meaningful apology; explain what is known at that time; identify what remains uncertain; offer appropriate support; explain the next steps; and provide a named point of contact.

4. Written confirmation	Provide written confirmation within five working days of the in-person notification, reflecting the discussion and the arrangements for further enquiries and contact.
5. Investigation and continued communication	Undertake proportionate enquiries under Putting Things Right, maintain appropriate communication and consider questions raised by the service user or representative.
6. Outcome, learning and improvement	Share the outcome of the investigation, explain the learning and action arising, and maintain records sufficient to demonstrate compliance and Organisational improvement.

A meaningful apology is an expression of sorrow or regret for the harm experienced. The Regulations define the Candour procedure and require a transparent response; the purpose is to maintain trust, support those affected and ensure learning is translated into improvement.

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

People Healthier Together
Pobl Iaachach Gyda'n Gilydd

The Duty of Candour Process in Wales

Being open, honest and learning when harm occurs

A statutory duty for NHS bodies in Wales

Open Honest Learning Together

1 Recognition and assessment

Identify the incident

- What happened?
- What harm occurred?
- Was healthcare provided, or may have been, a factor?
- Record the decision and rationale.

2 In-person notification

Tell the patient or their representative as soon as possible.

- This can be face to face, by telephone or by video call.
- The Duty of Candour should not wait until the investigation has concluded.

3 Apology, explanation and support

Be open and compassionate.

- Offer a meaningful apology.
- Explain what is known at that time.
- Identify what remains uncertain.
- Offer appropriate emotional and practical support.
- Explain the next steps and provide a named point of contact.

4 Written confirmation

Within 5 working days of the in-person notification.

- Provide a written summary of what was discussed.
- Include the apology.
- Explain the investigation process.
- Provide contact details for ongoing communication.

5 Investigation and continued communication

Carry out appropriate enquiries under Putting Things Right.

- Keep the patient or representative informed.
- Answer questions and provide updates.
- Maintain compassionate communication throughout the process.

6 Outcome, learning and improvement

Close the loop.

- Share the outcome of the investigation.
- Explain what happened and why.
- Identify the learning and actions taken.
- Use learning to improve care and reduce the risk of similar harm happening again.

When does the Duty of Candour apply?

The procedure applies when a patient experiences, or could experience:

Moderate harm | **Severe harm** | **Death**

AND

the healthcare provided was, or may have been, a contributing factor.

What is the Duty of Candour?

The Statutory Duty of Candour came into force across NHS Wales on 1 April 2023 under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and the Duty of Candour Procedure (Wales) Regulations 2023.

It is an organisational duty placed on NHS bodies to respond openly, compassionately and consistently when the threshold is met.

The Duty of Candour operates alongside the NHS Wales Listening to People, formally Putting Things Right arrangements. It does not depend on a patient or family first making a complaint.

A meaningful apology

"A meaningful apology is an expression of sorrow or regret for the harm experienced."

The Regulations require a transparent response; the purpose is to maintain trust, support those affected and ensure learning is translated into improvement.

This is not a complaints process

Duty of Candour is a separate statutory duty. It can (and should) be considered even if a complaint has not been made.

Our shared commitment

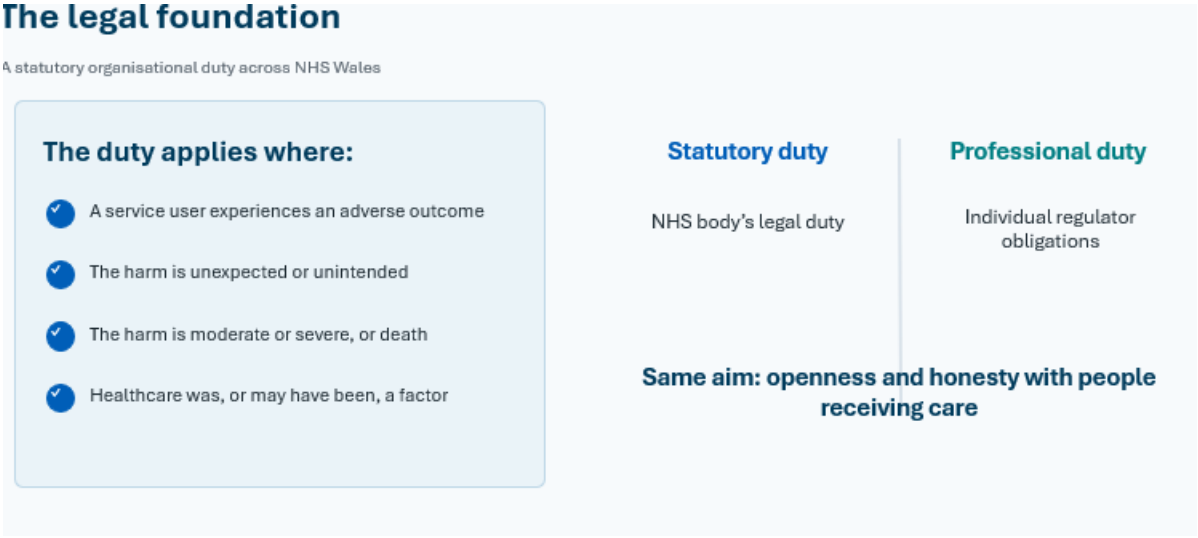
The Duty of Candour is underpinned by four key principles:

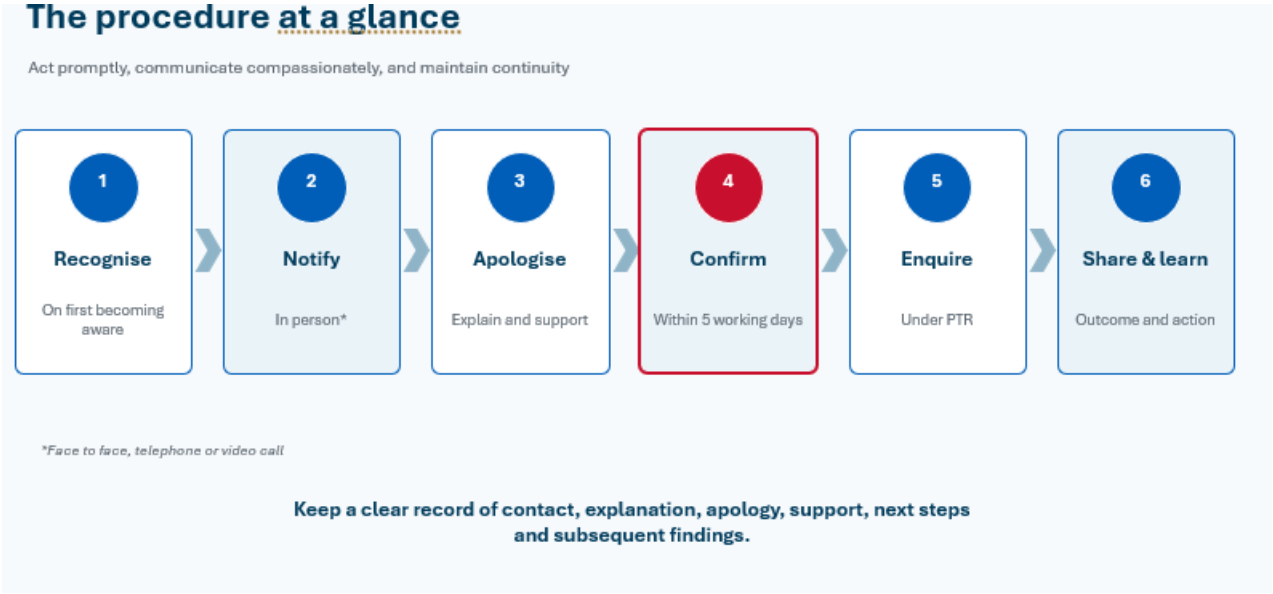
- **Apology** — Say sorry
- **Honesty** — Be open and transparent
- **Support** — Treat people with compassion and respect
- **Learning and improvement** — Use learning to make care safer

Caring for our communities
Building a healthier future

Gofalu am ein cymunedau
Adeiladu dyfodol iachach

Better Care Brighter Futures


The legal foundation
A statutory organisational duty across NHS Wales
The duty applies where:
A service user experiences an adverse outcome
The harm is unexpected or unintended
The harm is moderate or severe, or death
Healthcare was, or may have been, a factor
Statutory duty
NHS body's legal duty
Professional duty
Individual regulator obligations
Same aim: openness and honesty with people receiving care


The procedure at a glance
Act promptly, communicate compassionately, and maintain continuity
1
Recognise
On first becoming aware
2
Notify
In person*
3
Apologise
Explain and support
4
Confirm
Within 5 working days
5
Enquire
Under PTR
6
Share & learn
Outcome and action
*Face to face, telephone or video call
Keep a clear record of contact, explanation, apology, support, next steps and subsequent findings.

When does the duty apply?

Use the four-part test and record the rationale

1. **Adverse outcome**
   Has the person experienced harm?
2. **Unexpected or unintended**
   Was the outcome outside what was intended?
3. **Threshold**
   Moderate harm, severe harm or death?
4. **Contribution**
   Was or may NHS care have been a factor?



If uncertain, escalate promptly. Do not wait for the full investigation.

CARDIFF AND VALE UHB | DUTY OF CANDOUR

Mental Health Services 3

The first candour conversation

Human first, process second

Say	Offer	Avoid
• Acknowledge what has happened • Explain what is known now • Offer a sincere apology • Describe next steps	• Practical and emotional support • A named point of contact • Opportunity to ask questions • Preferred communication arrangements	• Speculation or premature conclusions • Defensive or technical language • Delaying contact for a final report • Treating the apology as legal liability

A meaningful apology is an expression of sorrow or regret. It is not acceptance of blame or legal liability.

Summary

This report provides the Committee with some assurance on the operation of the Statutory Duty of Candour from 1 April 2025 to 31 March 2026 and identifies recurring Organisational learning themes. The analysis comprises 216 records of these, 178 (82.4%) were closed; 12 were in management review, 13 were under investigation and 13 were awaiting closure.

The dominant safety themes are delays in referral, follow-up and surveillance; missed or delayed diagnostic results; avoidable pressure damage; delayed recognition and escalation of deterioration; peri-operative and procedural incidents; medication safety; and injurious falls. The recurrence of these themes indicates that risk is concentrated at interfaces between teams and services, particularly where responsibility for referrals, results, handover, transfer or follow-up is not reliably closed.

Compliance with Duty of Candour communication requirements is variable. Initial in person notification was recorded within 30 working days in 122 of 156 cases with a definitive response (78.2%). Written notification was recorded within five working days in 68 of 157 cases (43.3%). A final investigation response was recorded as sent in 92 of 140 cases where a definitive yes/no response was available (65.7%). Across all 216 records, 67 had no value recorded for response status. Blank or incomplete fields materially limit assurance. In some cases, fields were completed but the supporting documents had not been uploaded, preventing full verification.

Overall assessment: partial assurance. There is evidence of a functioning statutory process, a positive commitment to openness and substantial case closure. Further assurance is required on timeliness, data quality, consistent staff capability, dissemination of learning and delivery of measurable improvement in recurrent risk areas.

Purpose and Scope

This report provides the Board with an integrated assessment of Duty of Candour case activity, statutory process performance and staff feedback, and identifies the principal risks requiring organisational oversight. The current Datix crosstab contains 216 records graded following management review, during which the manager assesses whether the reporter's initial grading is appropriate and amends it where necessary.

The detailed listing used for thematic analysis contains 217 records, with reported dates of when the initial incident occurred as between 29 December 2023 and 30 March 2026; incident dates extend further back where harm was identified retrospectively.

5. Case Activity and Harm Profile

Measure	Number
Total records reviewed	216
Closed	178 (82.4%)
Under investigation	13 (6.0%)
Awaiting closure	13 (6.0%)
Management review	12 (5.6%)
Detailed listing records	216

Post-investigation harm assessment this is reviewed following completion of the investigation

Final harm assessment	Percentage of all records
Moderate	38.2%
Low	19.8%
Severe	18.0%
None	10.6%
Catastrophic / death	4.1%
Blank / not completed	9.2%

Principal Themes and Trends

The following thematic counts were derived from the descriptions of the incident and Duty of Candour circumstances. Themes overlap and should not be totalled, as individual records may contain more than one contributory theme.

Theme	Indicative records	Key assurance issue
Referral, follow-up and surveillance delay	63	Closed-loop pathway ownership, overdue action and patients lost to follow-up.
Diagnostic result, reporting or recognition failure	60	Abnormal results are not reliably acknowledged, escalated or acted upon.
Surgery, procedure and peri-operative care	57	Capacity constraints, handovers and specialist support.
Deterioration, NEWS and escalation	56	Observation frequency, escalation, senior review and appropriate care setting.
Pressure damage	50	Risk assessment, repositioning, equipment, documentation and transfer.
Medication management	34	Dose, route, omission, insulin, anticoagulation and critical infusions.
Falls	24	Risk assessment, supervision, equipment and reassessment after injury.
Maternity and neonatal care	18	Escalation, fetal/neonatal outcomes and family communication.
Contact, consent and communication barriers	18	Next-of-kin details, language support and appropriate representative.

Mental health, capacity and self-harm	14	Multi-agency coordination, physical health, capacity and self-neglect.

6.1 Cross-cutting interpretation

- Many serious events arose at organisational interfaces, including referrals between services, result handover, ward transfer, discharge and cross-organisational pathways.
- Several cases were recognised retrospectively following a scrutiny panel, mortality review, Claim, redress case, Inquest, complaint or Medical Examiner referral, which may delay disclosure and learning.
- Pressure damage and falls cases frequently relied upon later reviews to determine learning and harm level.
- Recorded reasons for delay commonly referred to ongoing reviews, redress consideration, sign-off, difficulty contacting patients or next of kin, administrative oversight and operational pressures.

Duty of Candour Process Assurance-this was a review of the regulatory process accordance

Process measure	Recorded outcome-yes	Assurance assessment-evidence on the file
Initial contact completed	150 (69.4%)	Variable. Contact barriers and incomplete fields require active exception management.
Initial notification within 30 working days	122 (56.5%)	Blank data remains significant.
Written notification sent	111 (51.4%)	Evidence of delivery, but a substantial number are outstanding or incomplete.
Written notification within five working days	68 (31.5%)	This is the clearest compliance gap.
Final investigation response sent	92 (42.6%)	Final-response control requires strengthening.

Total handling time was populated in only 14% of records. Because the field was sparsely completed, it should not be treated as a reliable organisation-wide performance measure; the incompleteness itself is an assurance concern.

Distribution by Clinical Board and Approval Status

The 216-record approval-status crosstab demonstrates that case volume and the concentration of identified cases vary across Clinical Boards. Medicine Services accounted for the largest volume, with 70 records, followed by Surgical Services with 37, Specialist Services with 36 and Children and Women's Services with 33.

Clinical Board	Total	Closed	Management review	Under investigation	Awaiting closure
Capital, Estates and Facilities	1	1	0	0	0
Children and Women's Services	33	27	3	2	1
Clinical Diagnostics and Therapeutic Services	9	9	0	0	0
Executive and Corporate Services	2	2	0	0	0
Medicine Services	70	60	2	1	7
Mental Health Services	17	11	2	3	1
Primary, Community and Intermediate Care	11	8	0	1	2
Specialist Services	36	24	5	5	2
Surgical Services	37	36	0	1	0
Total	216	178	12	13	13

The distribution should be interpreted in the context of service size, patient activity, case mix and reporting practice. It is not, in isolation, a measure of relative safety performance.

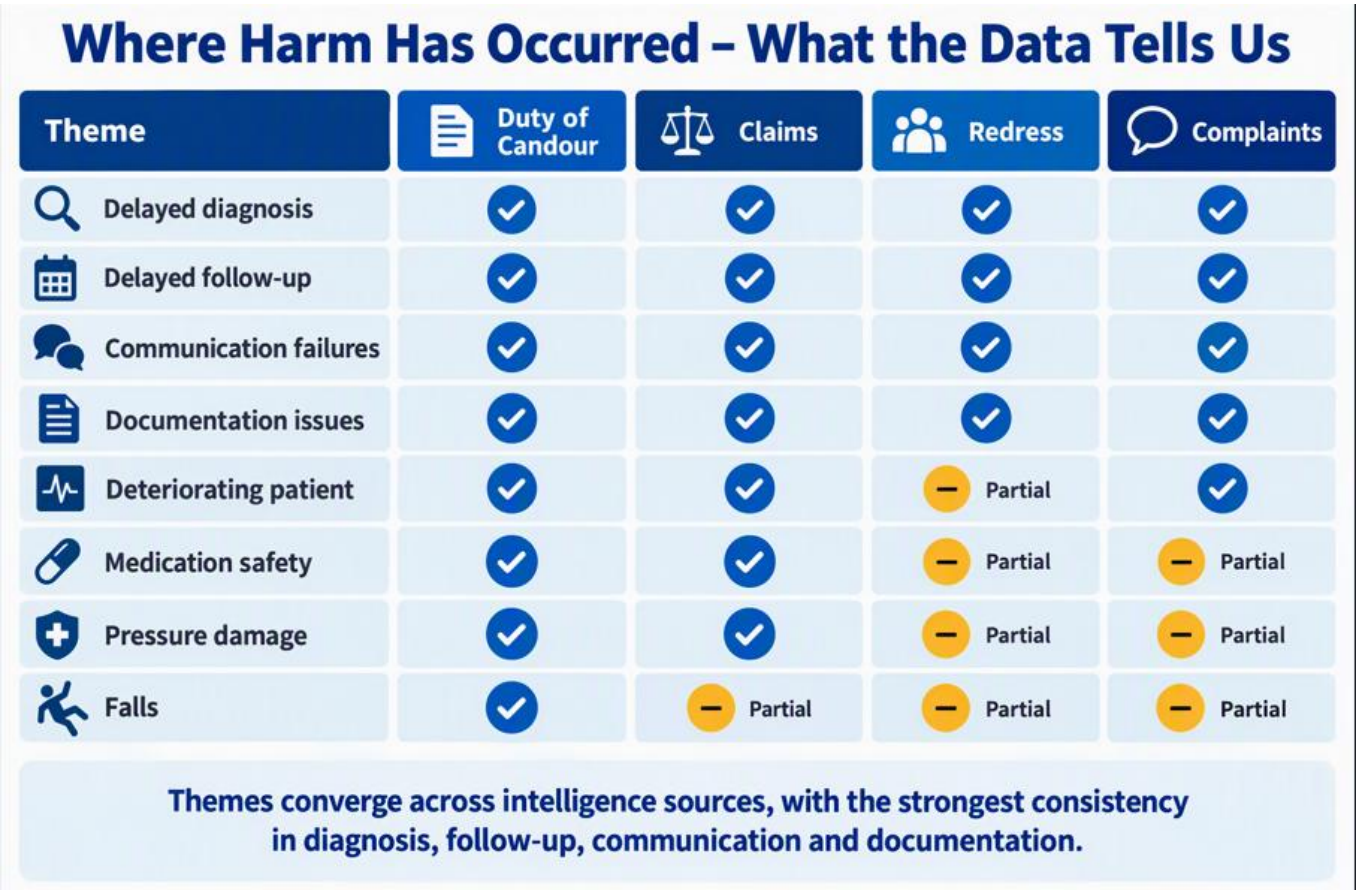
Learning From Harm: Triangulating Duty of Candour, Redress, Claims and Complaints

Why this matters

The themes identified through Duty of Candour do not exist in isolation. Analysis of claims, redress cases, complaints, inquests, and Learning Advisory Panel reviews demonstrates a high degree of alignment between the circumstances giving rise to Duty of Candour and the wider sources of organisational intelligence.

This triangulation provides greater confidence that the Health Board is identifying genuine system risks rather than isolated incidents and supports prioritisation of improvement activity in those areas most likely to contribute to patient harm.

Where Harm Has Occurred – What the Data Tells Us



Insight

The consistency of themes across all four intelligence sources indicates that the greatest risk to patients continues to arise at organisational interfaces where responsibility for referrals, investigations, follow-up, escalation, and communication is transferred between individuals, teams, or services.

Where Harm Should Trigger Consideration of Redress

A further finding from review of Duty of Candour cases is the need to ensure that cases involving moderate, severe, or catastrophic harm are routinely considered through the Redress framework where qualifying liability may exist.

The Duty of Candour process and Redress process serve different purposes but should operate in a complementary way:

Duty of Candour	Redress
Openness	Apology, in person, Resolution
Apology	Compensation where appropriate
Communication	Investigation of liability and explanation to patient/ family
Support	Learning and accountability

The introduction of Listening to People and the increased Redress threshold to £50,000 creates an opportunity to ensure earlier identification of appropriate Redress cases and reduce escalation into formal litigation thereby reducing legal costs and providing earlier opportunity for learning and risk mitigation.

Responding to the themes

The Health Board is already addressing many recurrent themes through the **Shaping Our Future Quality Excellence Programme**. The Programme provides a coordinated route from harm intelligence to action, measurable outcomes and governance assurance. The evidence below highlights where improvement effort should be concentrated; thematic counts overlap because a single case may contribute to more than one theme.

Patient and Family Experience

Patient and family feedback should directly inform improvements to communication standards, staff training, pathway design, case review and escalation arrangements. Measures should assess whether people felt:

- listened to and treated with compassion;
- involved in decisions and kept informed;
- given clear explanations and a meaningful apology; and
- offered appropriate support and a named contact.

Measuring Impact

Timeliness of data from Duty of Candour cases, recurring complaint themes, early resolution, escalation to formal concerns or redress, and feedback on whether changes were visible to those affected should be triangulated with safety outcomes. This will provide a clearer assessment of impact.

Clinical Board Accountability

Clinical Boards should review progress through their quality governance arrangements, address exceptions through time-bound recovery plans, and provide evidence that actions have been implemented and sustained.

Organisational Oversight

The Quality Management System and its dashboard should provide Organisational oversight, supported by regular reporting to the relevant executive governance group and the Quality Committee. Delivery or outcomes that remain off track should be escalated through performance reviews.

This establishes a clear line of accountability from Duty of Candour and patient experience intelligence to improvement action, assurance, measurable impact and reduced harm.

From intelligence to impact: Programme priorities and accountability			
Programme	**Evidence driving action**	**Priority action and measure**	**Accountability route and governance group**

Patients Lost to Follow-Up	**63** indicative records involved referral, follow-up or surveillance delay; **60** involved diagnostic-result, reporting or recognition failure.	Introduce closed-loop controls for referrals, results and surveillance. Monitor overdue pathways, acknowledged results, patients lost to follow-up and recurring incidents. Share clear information with patients so they can be active partners in their safety and care.	Clinical Board quality meetings
Deteriorating Patient	**56** indicative records involved deterioration, NEWS or escalation.	Strengthen observation, escalation and senior-review reliability. Monitor NEWS compliance, response times, unplanned deterioration and recurrent harm.	**Deteriorating Patient Programme group:** monitors delivery, outcome trends and exceptions. **Clinical Board quality governance group:** reviews local performance and recovery actions. Escalate off-track improvement through the governance route.
Medication Safety	**34** indicative records involved medication management, including dose, route, omission, insulin, anticoagulation and critical infusions.	Target prescribing, reconciliation, monitoring and administration controls. Measure high-risk medicine incidents, omissions and repeat themes.	**Medicines administration and management group:** reviews high-risk medicine incidents, controls and sustained impact. **Clinical Board quality governance groups:** assure local implementation.
Learning and Improvement	Only **27 of 71 staff (38.02%)** reported that learning from Duty of Candour cases was shared effectively within their service area.	Establish a consistent process for capturing, sharing and applying learning across Clinical Boards. Use a single dashboard to monitor learning actions, implementation, effectiveness and recurrence, alongside	**Clinical Board quality governance groups:** review how learning is shared, implemented and sustained, including evidence of impact and reduced recurrence. **Quality Management System:** triangulates learning from Organisational

		timeliness and data completeness.	intelligence and tests effectiveness.
Listening to People	**18** indicative records involved contact, consent or communication barriers. Only **31 of 72 staff (43.06%)** felt confident holding an open and honest conversation.	Strengthen early engagement, accessible communication, named contacts and timely resolution. Measure whether people felt listened to, informed, involved and supported, alongside early-resolution and escalation rates. A campaign to support and give staff support and confidence when undertaking these conversations.	**Patient Experience Peoples framework review:** reviews feedback, complaints, early resolution and redress intelligence. **Clinical Board quality governance groups:** oversee delivery of local actions.
Test: What changed, how do we know, and did it improve patient experience or reduce harm?			

. Assurance Assessment

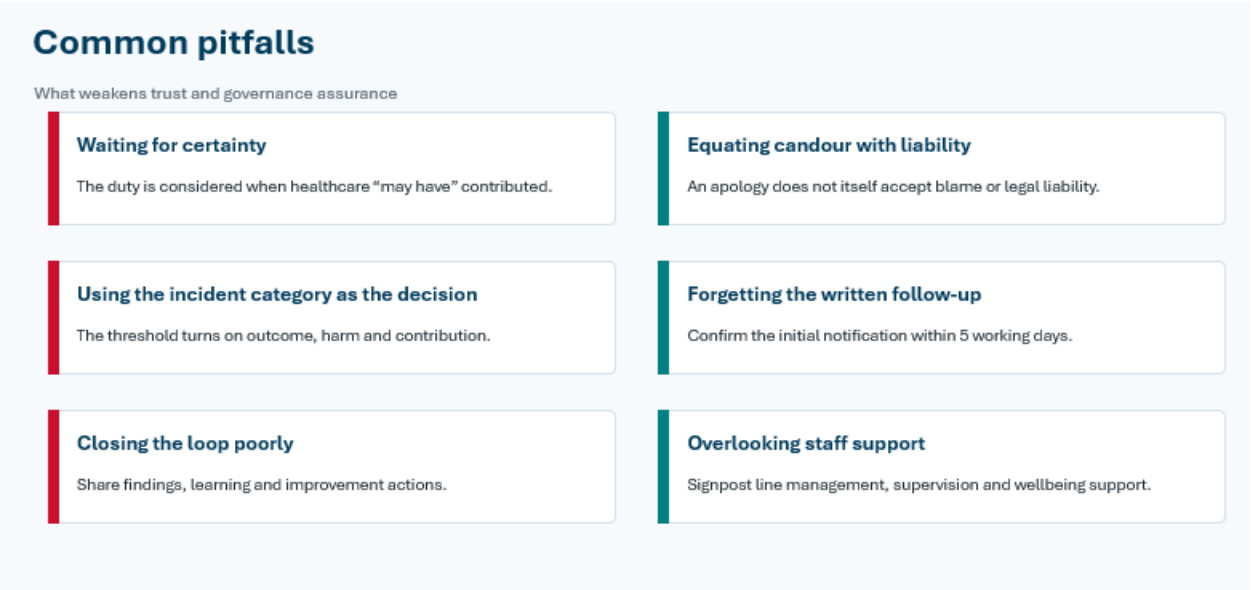
Assurance area	Assessment	Rationale
Statutory process in operation	Reasonable assurance	Substantial case identification, initial disclosure activity and high recorded closure.
Timeliness and completeness	Partial assurance	Written notification compliance, final responses and blank fields require improvement.
Identification of recurring risks	Reasonable assurance	Clear themes are visible across the dataset.
Evidence that learning is embedded	Limited assurance	Recurring incident types and weak staff perception of learning dissemination.
Staff capability and support	Partial assurance	Positive awareness and values, but gaps in training, practical confidence and access to resources.

Implications

Area	Implication
Quality and safety	The findings relate directly to safe, timely, effective and person-centred care and identify system risks requiring sustained oversight.
Patient and family experience	Delays or inconsistency in communication may compound distress following harm. Communication should be timely, compassionate and tailored to individual needs.
Workforce	Delivery requires protected time, confident managers, accessible specialist advice and emotional support for staff involved.
Equality and Welsh language	Communication arrangements should consider language, accessibility, capacity, consent and the identification of an appropriate representative.
Resources	Recommendations may require prioritisation of digital controls, training capacity, specialist advice and Clinical Board improvement resource.
Reputation and compliance	Failure to meet statutory process requirements or demonstrate learning may create regulatory, reputational and public-confidence risk.

Conclusion

There are some common reasons why there is an assurance gap



Overall assurance. The Health Board has established a functioning Duty of Candour process, and staff broadly support its role in promoting openness, transparency and learning. However,

the case analysis and staff survey identify material gaps in timeliness, documentation, practical confidence and the sharing of learning. Recurring themes also demonstrate that improvement must extend beyond individual case management to strengthen Organisational controls at pathway and service interfaces. The Board is therefore asked to note the partial assurance assessment and endorse the priority actions set out in this report.

Learning and impact. The recurring Duty of Candour themes align with intelligence from complaints, redress, claims, inquests and Learning Advisory Panel reviews. This triangulation provides confidence that the Health Board is identifying the principal Organisational risks. The priority for 2026/27 is therefore to move beyond identifying learning and demonstrate that actions have been implemented, sustained and evaluated. Organisational learning must translate into measurable improvements in safety and patient experience, reduced recurrence and less harm.

Staff insight. A staff survey was undertaken to assess perceptions of the Duty of Candour process and identify the support required to improve confidence and delivery. The key findings are summarized below, with the full survey results provided in Appendix 1.

Staff Survey Findings

The survey received 124 responses. Denominators varied by question and percentages below are reported against the number answering each question.

Survey indicator	Result	Interpretation
Awareness of Duty of Candour	99 of 124 (79.84%) aware	General awareness is positive, but one in five respondents reported no awareness.
Completed Duty of Candour training	41 of 87 (47.13%) had completed training; 46 (52.87%) had not	Training coverage is insufficient among those answering this question.
Understands what DoC is and when it applies	50 of 72 (69.44%) agree/strongly agree	Conceptual understanding is stronger than practical confidence.
Confident recognizing when DoC is triggered	39 of 72 (54.17%) agree/strongly agree	Nearly half did not express positive confidence.
Confident holding an open and honest conversation	31 of 72 (43.06%) agree/strongly agree	Practical communication confidence is a key development need.
DoC supports openness and transparency	55 of 72 (76.39%) agree/strongly agree	Strong support for the principle and Organisational purpose.
DoC encourages learning rather than blame	46 of 71 (64.79%) agree/strongly agree	Positive overall, with a quarter neutral and 9.86% disagreeing.

Learning effectively shared within service area	27 of 71 (38.02%) agree/strongly agree	The weakest positive score and a material learning-system concern.
Knows where to access guidance, templates and support	30 of 71 (42.25%) agree/strongly agree	Access and visibility of resources require improvement.

Priority support needs identified by respondents

Support requested	Responses	Percentage (n=87)
Further training	45	51.72%
Case studies and examples	36	41.38%
Clearer guidance	28	32.18%
Time and capacity	26	29.89%
Access to specialist advice	20	22.99%
Managerial support	16	18.39%
Emotional / wellbeing support	14	16.09%
No additional support required	15	17.24%

Qualitative Feedback

Comments highlighted five consistent priorities: regular and accessible refresher training; wider use of case studies and practical examples; face-to-face development for managers; routine team discussion of Duty of Candour cases; and compassionate, supportive management.

Respondent Profile and Survey Limitations

The respondent profile was weighted towards experienced nursing and midwifery staff and two Clinical Boards:

• Nursing and midwifery staff accounted for 47 of 94 responses to the staff-group question (50.0%).

• Children and Women's Services and Primary, Community and Intermediate Care together accounted for 51 of 93 Clinical Board responses.

• Of the 94 respondents who answered the length-of-service question, 81 (86.17%) had more than five years of NHS service.

The findings therefore provide valuable insight from experienced staff but should not be treated as a representative workforce benchmark across all staff groups or Clinical Boards.

Key Survey Findings

The survey indicates that staff broadly understand and support the principles of openness and transparency. However, it also identifies important gaps in training, practical confidence, access to guidance and the effective sharing of learning.

Of the 124 respondents, 99 (79.84%) were aware of the Duty of Candour. However:
• 46 of 87 respondents to the training question (52.87%) had not completed training;
• only 31 of 72 respondents (43.06%) felt confident holding an open and honest conversation; and
• only 27 of 71 respondents (38.02%) believed that learning was shared effectively within their service area.

Key Message is *Duty of Candour is not simply a legal requirement. It is a fundamental component of person-centred, compassionate, and safe healthcare, ensuring patients and families are treated with honesty, dignity, and respect when harm occurs.*

Recommendations to Improve the process and assurance

- **Incident management:** Clinical Boards commit to reducing incident backlogs and ensure cases progress promptly through review, investigation and closure.
- **Initial harm assessment:** Train incident reporters to assess and record the initial level of harm accurately and consistently.
- **Training and support:** Develop a revised Duty of Candour offer that includes refresher training, case-based learning, practical conversation skills and accessible central guidance.
- **Exception reporting:** Issue a monthly report covering overdue notifications, written correspondence and final responses, together with incomplete harm assessments and cases awaiting sign-off or redress consideration.
- **Learning and improvement:** Clinical Boards are required to evidence that learning actions have been implemented, sustained and achieved measurable improvement, with particular focus on pressure damage, deteriorating patients, medicines safety and falls.
- **Develop Templates-** These have been developed and disseminated

Early identification: Ensure the Duty of Candour is considered independently of whether a complaint has been made and without waiting for the full investigation to conclude.

Documentation and audit: Establish an ongoing audit Programme to confirm that supporting documentation is uploaded to the central system and that compliance can be monitored and verified.

Appendix one

Duty of Candour Staff Feedback Survey: Full Results

Survey: Feedback Questionnaire (Duty of Candour) | Survey period: 6 May to 17 June 2026 | Total respondents: 124 | Report generated: 15 July 2026 at 6:58 am. Response totals vary by question.

Question 1: Are you aware of the Duty of Candour?

Available answer	Responses	Score
Yes	99	79.84%
No	25	20.16%

Total	**124**	**100%**

Question 2: Have you completed Duty of Candour training?

Available answer	Responses	Score
Yes, in the last 12 months	18	20.69%
Yes, over 12 months ago	23	26.44%
No	46	52.87%
Total	**87**	**100%**

Question 3: What additional support would help you feel more confident delivering the Duty of Candour? Please choose all that apply.

Support option	Responses	Score
Further training	45	51.72%
Case studies / examples	36	41.38%
Clearer guidance	28	32.18%
Managerial support	16	18.39%
Time and capacity	26	29.89%
Access to specialist advice	20	22.99%
Emotional / wellbeing support	14	16.09%
Other, please specify	2	2.30%
I don't require additional support	15	17.24%
Respondents	**87**	**Multiple responses permitted**

Other responses: circulation of information so staff are aware; refresher training rather than full training.

Question 4: Have you been involved in a Duty of Candour process in the last 12 months?

Available answer	Responses	Score
Yes	21	24.14%
No	66	75.86%
Total	**87**	**100%**

Question 5: Did you feel supported during this process?

Available answer	Responses	Score
Yes, always	10	55.56%
Yes, sometimes	7	38.89%
No	1	5.56%
Not applicable, as I was not a CAV UHB employee at the time	0	0.00%
Total	**18**	**100%**

Respondents involved in more than one process were asked to base their answer on the most recent and only on support offered or provided by Cardiff and Vale UHB.

Questions 6–12: Attitudes, confidence and access to support

Question	Strongly agree	Agree	Neither	Disagree	Strongly disagree
6. I understand what the Duty of Candour is and when it applies. (n=72)	18 (25.00%)	32 (44.44%)	15 (20.83%)	5 (6.94%)	2 (2.78%)
7. I feel confident recognising when the Duty of Candour is triggered. (n=72)	13 (18.06%)	26 (36.11%)	22 (30.56%)	9 (12.50%)	2 (2.78%)
8. I feel confident having an open and honest conversation with a client, service user or family under the Duty of Candour. (n=72)	13 (18.06%)	18 (25.00%)	25 (34.72%)	13 (18.06%)	3 (4.17%)
9. I believe the Duty of Candour supports a culture of openness and transparency within Cardiff and Vale UHB. (n=72)	24 (33.33%)	31 (43.06%)	14 (19.44%)	1 (1.39%)	2 (2.78%)
10. I feel the Duty of Candour process encourages learning and improvement, rather than blame. (n=71)	17 (23.94%)	29 (40.85%)	18 (25.35%)	5 (7.04%)	2 (2.82%)
11. Learning from Duty of Candour cases is effectively shared within my service area. (n=71)	10 (14.08%)	17 (23.94%)	26 (36.62%)	12 (16.90%)	6 (8.45%)
12. I know where to access Duty of Candour guidance, templates and support within Cardiff and Vale UHB. (n=71)	8 (11.27%)	22 (30.99%)	19 (26.76%)	15 (21.13%)	7 (9.86%)

Question 13: Additional comments on experience, support needs or suggestions

- Regular, easy-to-access training and broader sharing of Duty of Candour examples. One lead offered to consider how these conversations could take place regularly within the

team and noted that few examples of Duty of Candour conversations were heard from senior managers.
- Consider making Duty of Candour mandatory training, repeated every two years to keep it fresh in staff members' minds.
- Face-to-face study days for managers would be helpful.
- Aware of training.
- One respondent was unsure whether they were the right person to complete the survey because they were non-patient facing.
- Not applicable.
- Managers need to be more empathetic.

Question 14: To which staff group do you belong?

Staff group	Responses	Score
Medical	7	7.45%
Nursing / Midwifery	47	50.00%
Allied Health Professional	15	15.96%
Healthcare Support Worker	4	4.26%
Manager	1	1.06%
Corporate / non-clinical	8	8.51%
Other, please specify	7	7.45%
I prefer not to say	5	5.32%
Total	**94**	**100%**

Other responses: Health science; A&C; Estates; admin; Union Rep.

Question 15: Which Clinical Board do you primarily work for?

Clinical Board	Responses	Score
Children and Women	27	29.03%
Clinical Diagnostics and Therapeutics	11	11.83%
Medicine	6	6.45%
Mental Health	4	4.30%
Primary, Community and Intermediate Care	24	25.81%
Specialist Services	9	9.68%
Surgery	1	1.08%
Other, please specify	7	7.53%
I prefer not to say	4	4.30%
Total	**93**	**100%**

Other responses: PCIC; ICCS; Staff side; pharmacy; Exec & Corporate.

Question 16: How long have you been an NHS employee?

Length of service	Responses	Score
Less than 6 months	0	0.00%
6 months–2 years	3	3.19%
2–5 years	9	9.57%
More than 5 years	81	86.17%
I prefer not to say	1	1.06%
Total	**94**	**100%**

Report Title: *(needs to match agenda)*	Consent		Agenda Item No:		8.1
Meeting:	Quality Committee	Public	X		27.10.2026
		Private			
Lead Executive Title:	Jason Roberts, Executive Nurse Director				
Report Author/s Title:	Chloe Evans, MCA and Consent Team 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).*

The Welsh Risk Pool review concluded that Cardiff and Vale UHB can take **reasonable assurance** in relation to decision making and consent. However, material gaps remain: procedure-specific patient information leaflets and training were assessed as **partially compliant**, and the Health Board-wide monitoring and review of consent practice was assessed as **non-compliant**. The absence of a consistent organisation-wide audit and peer-review programme is the principal assurance gap and requires strengthened oversight and delivery.

- **PSPIL governance:** a complete inventory, clear ownership, review dates and notification arrangements are not yet fully established.
- **Training:** overall compliance has improved, but medical and dental compliance remains below the required standard.
- **Monitoring and review:** a standardised Health Board-wide audit, action-tracking, reporting and learning process is not yet in place.

An action plan is in place, led by the Consent Lead with oversight through the CAV Consent Group. The Quality Committee will receive quarterly progress reports, including delivery against recommendations, training compliance by staff group, audit findings, outstanding risks and evidence that improvement actions have been completed and sustained.

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

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

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

Recommendations

The Quality Committee is asked to:

1. Receive assurance from the Welsh Risk Pool's overall Reasonable Assurance rating, while noting the areas of partial and non-compliance identified in the review.
2. Note the action plan developed in response to the recommendations, including the priority actions relating to PSPIL governance, training compliance and the establishment of a Health Board-wide consent audit and peer-review programme.
3. Recognise the continuing assurance gap arising from non-compliance in monitoring and review, and the need for sustained executive and Clinical Board oversight.

4. Receive quarterly progress reports setting out delivery against the action plan, training compliance by staff group, audit findings, outstanding risks, escalations and evidence that improvements have been completed and sustained

Governance Route *(please list all other Committee/Groups this report has been to)*	
***Where** it's been:*	Safeguarding Steering Group
***When** it went:*	15.09.2026
***What** decision was made:*	For alerting to quality committee

Main Report
Background & Current Situation

Purpose
The purpose of this report is to present the findings and assurance rating from the Welsh Risk Pool National Review of Decision Making and Consent to Examination and Treatment, outline the Health Board's response to the recommendations, and provide assurance on the governance arrangements, actions and oversight in place to address identified gaps and sustain improvement

Background
The UHB has indemnity arrangements in place provided through the Welsh Risk Pool (WRP) which offers protection against financial claims and litigation relating to consent.

The WRP conducted a review of Decision Making and Consent to Examination and Treatment Standards at CAV UHB during 2025/6 with the aim to assess clinical application of the All Wales Consent to Examination or Treatment model policy. A draft report was shared on 1st April and the final report was issued on 30th September 2026.

The Review Team have determined an overall assurance rating of *Reasonable Assurance,* and outline the matters that require management attention, making a series of recommendations for improvement. The assessment tool considered five areas of assessment, with a compliance rating for each of the following:

1. Policy and Management of Decision Making and Consent to Examination and Treatment - *COMPLIANT*
2. Consent Forms including Procedure Specific Consent Forms (PSCFs) - *COMPLIANT*
3. Procedure Specific Patient Information Leaflets (PSPIL) including locally developed PSPILs – *PARTIALLY COMPLIANT*
4. Training – *PARTIALLY COMPLIANT*
5. Monitoring and Review of the Consent Policy and process, use of consent forms / PSCFs and PSPILs.- *NON COMPLIANT*

1. Policy and Management of Decision Making and Consent to Examination and Treatment

i. Timely review of the Consent to Examination and Treatment policy to ensure alignment with the All Wales Model Policy and current professional and legal requirements.
ii. Review of CAV Consent Group to ensure sufficient representation from clinicians across the UHB, reflecting the central role of these staff groups in decision making and consent.

2. Consent Forms including Procedure Specific Consent Forms (PSCFs)

i. Preparations are underway for a pilot of EIDO eConsent within general surgery. The intended model will support provision of procedure-specific information, recording of the patient's access to information and questions, completion of the consent form, and a clear audit trail. The pilot will require agreed information-governance, clinical-safety and records-management arrangements, defined measures of patient and staff experience, and evaluation before wider implementation. Digital consent will support, rather than replace, the clinician-patient dialogue and reasonable adjustments or non-digital routes must remain available.

3. Procedure Specific Patient Information Leaflets (PSPIL) including locally developed PSPLs

i. The EIDO patient-information library is established at CAVUHB, but its use is variable and should be extended more widely, particularly in areas where high frequency procedures are being performed.
ii. Where an EIDO or suitable professional-body leaflet is not available, locally developed procedure-specific patient information leaflets (PSPILs) must follow the approved governance process.
iii. Current improvement work includes:
    a. A pilot anaesthetic pre-assessment leaflet using QR codes to give patients convenient access to relevant information in advance, while retaining printed and accessible alternatives.
    b. The Consent Lead will oversee the development of a Health Board-wide inventory and audit of PSPILs by April 2027.
iv. The Consent Lead will ensure that new locally developed PSPILs are reviewed prior to approval to ensure that they are compliant with relevant policies / legislation and will liaise with EIDO to ensure that new relevant PSPILs developed by professional bodies are added to the library.

4. Training

ii. CAVUHB has mandated the All Wales Decision Making and Consent training since August 2024 for all professional staff, with refresher training every three years. The training module is part of the Induction programme and is also available for staff on the Electronic Staff Record (ESR).
iii. Face-to-face or other alternative training may be recognised only where it meets the WRP standard and completion is verified and recorded on ESR, preventing unnecessary duplication.
iv. Training is now above the WRP standard of 85% (87.2% overall as at 30th September 2026) however, Medical and Dental compliance remains significantly lower at 61.9%. This is a significant assurance gap as this group commonly leads consent discussions and carries responsibility for documenting material risks, reasonable alternatives and the patient's individual priorities.
v. The Deputy Executive Medical Director is looking for solutions to address this issue
vi. The Consent Lead will work with the Deputy Executive Medical Director, Clinical Boards, Medical Education and the ESR team to improve compliance. Some immediate actions are:
    a. Promote the training requirement through induction, SharePoint, screensavers, the consent newsletter and medical education channels.

b. Inclusion of representatives from Medical and Dental in the CAV Consent Group to provide clinical ownership, help identify specialty-specific learning needs and support dissemination.
c. Record WRP-approved alternative training consistently on ESR following review by the Consent Lead;
d. Training compliance alone will not be treated as evidence of competent practice: audit findings, incidents, complaints and claims will be used to target additional education and improvement work.
e. Report compliance by staff group and Clinical Board to the CAV Consent Group bi-monthly, with escalation to the Quality Committee where the 85% standard is not achieved or sustained.

5. Monitoring and Review of the Consent Policy and process, use of consent forms / PSCFs and PSPILs.

This was the only area rated non-compliant by the Welsh Risk Pool (WRP) review and remains the Health Board's main assurance gap. Existing audits and reviews do not yet provide a consistent Health Board-wide programme, standard methodology, robust reporting, or systematic learning.

Conclusion
To address this, a Health Board-wide Consent Assurance Programme will be established by March 2027, based on the All Wales peer review methodology and supported by specialty-specific measures where required.

The programme will focus on the quality of the consent process, including:

- Evidence of informed decision making and patient-centred discussions.
- Documentation of benefits, material risks, alternatives and the option of no treatment.
- Capacity assessments, best-interest decisions and reasonable adjustments where required.
- Appropriate use of consent forms and procedure-specific consent forms (PSCFs).
- Provision of approved patient information in accessible formats.

Audits and peer reviews will generate action plans with named leads and completion dates, with unresolved risks escalated through governance routes. Findings will be reported to the Consent Group and Quality Committee, alongside training compliance, document governance, incidents, complaints, claims, eConsent pilot outcomes and evidence of improvement. Learning identified through reviews will be shared with clinicians and teams to support continuous improvement.

The newly appointed Consent Lead will take the lead in progressing and implementing the recommendations outlined in the Action Plan, with support from the CAV Consent Group.

The Committee will be provided with quarterly updates outlining progress with the Action Plan. This will include an overview of key achievements, areas of outstanding concern and results of relevant audits to provide a timely update of the UHB’s current position and compliance with required standards.

In addition to providing assurance to the WRP that the Review Findings are addressed, it is also proposed that other initiatives promoting further improvement in the Consent processes will be integrated into the Plan, as outlined above, to ensure that applicable standards can be sustained long term.

Appendices:

- WRP National Review - Consent to Examination and Treatment 30th September 2026
- Action Plan in response to recommendations arising from the 2025/26 National Review of Decision Making and Consent to Examination & Treatment Standards in NHS Wales

Strategic Alignment – Shaping Our Future Wellbeing:

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

Impact Assessment

Risk: Yes

Failure to obtain and document valid, informed consent creates clinical, legal and organisational risk. The action plan mitigates this through strengthened policy oversight, training, document governance, audit, action tracking and escalation.

Safety: Yes

There is a risk of harm where patients are not given sufficient information about benefits, material risks, alternatives and the option of no treatment, or where capacity, best-interest decision making and reasonable adjustments are not appropriately considered and recorded.

Financial: Yes

Inadequate consent may result in avoidable claims, litigation and Welsh Risk Pool exposure. Delivery of the action plan and proposed eConsent pilot may require staff time and implementation resource; any wider digital rollout should be subject to evaluation and appropriate business-case approval.

Workforce: Yes

The review has implications for mandatory training, induction, clinical leadership, audit participation and local action-plan delivery. Particular focus is required to improve and sustain Medical and Dental training compliance and ensure staff understand their responsibilities within the consent process.

Legal: Yes

Consent practice must comply with relevant legal and professional requirements, including valid informed consent, mental capacity and best-interest decision making. Failure to do so may result in claims, litigation, regulatory scrutiny and challenge to the lawfulness of treatment.

Reputational: Yes

Poor consent practice, non-compliance or related claims could reduce public and staff confidence. Transparent oversight, timely action and evidence of sustained improvement will help protect organisational reputation.

Socio Economic: Yes

People experiencing socio-economic disadvantage may face greater barriers to accessing, understanding or acting on health information, including digital exclusion. Implementation must retain non-digital routes, accessible information and appropriate support so that consent processes do not widen inequalities of outcome.

Equality & Health: Yes

Consent information and discussions must be accessible, culturally appropriate and responsive to individual communication, sensory, cognitive, language and capacity needs. Reasonable adjustments, interpretation, advocacy and alternative formats must remain available, with audit used to identify and address unequal experience or outcomes.

Decarbonisation: No

No significant adverse impact is anticipated. Digital information and consent processes may reduce printing and paper use, but environmental benefits should be proportionate and must not replace accessible printed options where these are required.
Welsh Language: Yes
Consent forms, procedure-specific information and digital developments must comply with Welsh Language Standards and provide an active offer in Welsh. Welsh-language materials should be equally accessible, current and available at the same time and to the same standard as English-language versions.

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Cronfa Risg Cymru
Shared Services Partnership
Welsh Risk Pool Services

A National Review of Decision Making and Consent to Examination & Treatment Standards in NHS Wales

A report by the Welsh Risk Pool Safety and Learning Team

Gwneud Penderfyniadau a Chydsyniad
Decision Making and Consent

Cardiff and Vale University Health Board

Draft report issued: 31st March 2026

Action Plan received: 17th June 2026

Final Report Issued: 30th September 2026

Gwella Diogelwch Cleifion Trwy Ddysgu
Improving Patient Safety Through Learning

REPORT STATUS: FINAL

A national review of Decision Making and Consent to Examination & Treatment Standards in NHS Wales has been undertaken with the aim to further improve patient safety and compliance in relation to the process for decision making, sharing information and obtaining informed consent to examination and treatment.

This report is issued following a draft release on 1st April 2026 which provided an opportunity for your organisation to review the information for factual accuracy and to present an action plan to address the recommendations.

The action plan was requested by 1st May 2026 and received on 17th June and can be found in Section 7. There were no requests made in relation to factual accuracy.

The report and action plan can be used for internal quality assurance processes within the organisation, and the Welsh Risk Pool will use this information as part of future assurance processes.

The Decision Making and Consent team hope that the feedback and recommendations in the report are valuable and provide your organisation with useful guidance for further development of your consent processes and associated improvements in clinical practice.

With thanks to all colleagues at Cardiff and Vale UHB for their time in supporting the consent assessment.

The Welsh Risk Pool Assessment Team

Sponsor

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7 Health Body's Action Plan

Appendix 1: Welsh Risk Pool (WRP) Assessment Tool – Decision Making and Consent (Consent)

Appendix 2: NHS Wales Assurance Framework

Appendix 3: Action Plan Template

1 Introduction

1.1 The Welsh Risk Pool oversees the National Programme for Decision Making & Consent. The rationale for this work being supported by the Welsh Risk Pool Committee is the proportion of new letters of claim which present allegations in relation to the consenting process. The principal aim is to assess the areas of activity which directly impact on the Decision Making and Consent to Examination and Treatment process in Health Bodies and which may cause a request for reimbursement from the Welsh Risk Pool.

1.2 The Welsh Risk Pool Committee periodically undertakes assessments of the progress made in organisations in relation to Decision Making & Consent. The most recent assessment was undertaken in 2022-2023 and a series of recommendations were issued to all Health Bodies in NHS Wales in May 2023.

1.3 The Welsh Risk Pool (WRP) Committee requested that the Welsh Risk Pool Safety & Learning Team undertake a further assessment of all organisation's policies and their clinical application against the All-Wales Consent to Examination or Treatment Model Policy. This review was commissioned to take place during 2025-2026.

1.4 This review has considered each organisation's policy and practice since 2023 with obtaining informed consent and considers whether key findings identified in the previous report and its recommendations have been progressed.

2 Background

2.1 A review of letters of claim and letters of notification for clinical negligence matters highlighted that around 1 in 5 cases involved allegations of failings with issues related to consent, a failure to provide patients with information, and failures to document what information was provided.

2.2 In particular, many claims involved failures to discuss the benefits and risks (including material risks) of the proposed treatment and the benefits and risks of any available alternative treatments (including no treatment).

2.3 In response to the high proportion of claims where allegations of failings with issues relating to consent were raised, with the agreement of the Welsh Risk Pool Committee a national programme was set up by the Welsh Risk Pool in 2020 to support Health Bodies in Wales to comply with and address failures in their consent processes. The national programme:

- Established a National Decision Making and Consent Team
- Supports the All Wales Decision Making and Consent Group
- Has taken ownership of and review / approval of the All Wales Model Policy for Consent to Examination or Treatment (AWMCP)
- Has taken ownership of and the review of All Wales Consent Forms 1,2 & 4
- Developed an All Wales Procedure Specific Consent Form (PSCF) template
- Developed principles and framework for the development and approval of Health Board / Trust Procedure Specific Consent Forms [Suggested content]
- Developed an example checklist - Local Procedure Specific Patient Information leaflets (PSPILs) to be used in the consent to examination and treatment process
- Commissioned an All Wales portfolio of consent information leaflets (CanolfanEIDOCymru) and this has recently been updated to include a digital platform to enable the inclusion of locally produced leaflets
- Commissioned a bespoke e-Learning package in Decision Making & Consent in Wales and more recently a learning package in End of Life Decision Making
- Commissioned a bespoke e-leaning induction video on Consent
- Developed a methodology and peer review tool which Health Bodies can adopt should they wish to monitor their compliance in regard to consent.

3 Method

3.1 Terms of Reference for the assessment, an assessment tool outlining the areas for assessment and evidence submission sheet were developed and circulated to each organisation's executive and operational Lead(s) for consent to assist in identifying the evidence required.

3.2 Identified Health Body representatives were asked to undertake a self-assessment using the 'Welsh Risk Pool (WRP) Assessment Tool – Decision Making and Consent (Consent)' (Appendix 1) and upload their collated evidence to a Health Body specific SharePoint folder hosted by NHS Wales Shared Services Partnership. The assessment tool was divided into 5 'Areas for Assessment' which provided a framework for the Health Body's assessment team to gather and submit the evidence.

3.3 The period provided was 31st May 2025 to 31st July 2025 and extensions were granted on an individual basis on request. The quality of the evidence submitted varied between Health Bodies and where evidence was insufficient to complete a robust analysis, further requests for supporting evidence were made with a deadline of 6th February 2026. Further requests for extensions were made by some organisations and all submissions were finally received by 25th February 2026.

3.4 By completing the assessments and having the opportunity to clarify and update the information already submitted a number of organisations have managed to improve their compliance with the areas of assessment made since the original evidence was submitted in July 2025.

3.5 Evidence was analysed by the WRP Safety & Learning Team. Themes were identified and a series of recommendations for improvement developed.

4 Review Findings

4.1 Area for Assessment 1

Policy and Management of Decision Making and Consent to Examination and Treatment

4.1.1 The Health Body has adopted the All Wales Model Policy for Consent to Examination or Treatment (AWMCP) and the policy has been in effect for over 12 months. The policy was formally ratified by the Quality, Safety & Experience Committee on 30th August 2023.

4.1.2 The policy has a review date of 30th August 2026 as per the Health Body's 3 year period for a formal review.

4.1.3 The Health Body has effective procedures for responding to amendments to the national model policy when published, by ensuring it has representation at the All Wales Decision Making and Consent Group.

4.1.4 The policy is formally publicised throughout the Health Body and is visible and accessible to staff via the consent SharePoint page.

4.1.5 The Health Body has other policies which support the Consent Policy and their review is consistent with Health Body requirements.

4.1.6 The Health Body has a Decision Making and Consent Group that meets every quarter. Evidence of its Terms of Reference and to which this Group reports have not been provided

4.1.7 Health Body senior management staff are aware of the pathway (including escalation) for seeking advice in relation to issues which may arise in relation to consent. A flow chart is also in development. Appendix C of the Consent Policy provides a link for seeking advice although the link was found to be non-functioning when accessed. There is also support via the Corporate Governance Legal Advice page which directs staff to the Consent Team.

Compliance with Standard: Compliant

4.2 Area for Assessment 2

Consent Forms including Procedure Specific Consent Forms (PSCFs)

4.2.1 The Health Body uses All Wales Consent Forms 1, 2 and 4.

4.2.2 The Health Body uses Procedure Specific Consent Forms (PSCF) and has approved and adopted the All Wales PSCF template as its local PSCF template. It has developed a method of carbonating locally developed PSCFs which is seen as good practice.

4.2.3 The Health Body has formal guidance - Development and Approval of UHB Procedure Specific Consent Forms Principles and Framework which provides a governance process for the development, approval / ratification, Welsh language translation and reader panel approval, noting and review of local PSCFs.

4.2.4 The local PSCF template and guidance are formally publicised throughout the Health Body and are visible and accessible to staff on the consent SharePoint page.

4.2.5 The PSCF guidance was ratified by the Quality, Safety and Experience Committee on 26th November 2024 and has a review date of December 2027.

4.2.6 Locally developed PSCFs are compliant with Welsh Language standards. Scrutiny for readability is done via the relevant specialty's reader panel (stakeholder reference group & virtual editorial panel).

4.2.7 Links to local PSCFs are available via the specialties' SharePoint page and can be download, e.g., in outpatient clinics.

4.2.8 The Health Body has a database of locally developed PSCFs recording ownership. It is unclear who maintains this register and the review dates / who monitors the review dates.

Compliance with Standard: Compliant

4.3 Area for Assessment 3

Procedure Specific Patient Information Leaflets (PSPIL) including locally developed PSPLs

4.3.1 The Health Body uses WRP approved PSPILs that illustrate the risks, benefits and alternatives of common elective treatments (including no treatment). EIDO usage reports reflect this.

4.3.2 The Health Body promotes the use of EIDO or professionally recognised PSPILs using its consent SharePoint page and business page.

4.3.3 Healthcare professionals can easily access EIDO or professionally recognised PSPILs via links on the consent SharePoint page and business page.

4.3.4 If there is a need to develop local PSPILs, the Health Body has developed guidance and a governance process to produce, develop content, approve, ratify, note and review locally developed leaflets.

4.3.5 The PSPIL guidance - Development and Approval of UHB Local Procedure Specific Patient Information Leaflets Principles and Framework is noted in unconfirmed minutes of the Public Quality Safety and Experience Committee on 8th October 2024. It has a 3 yearly review as per policy of 8th October 2027.

4.3.6 The local PSPILs guidance is formally publicised throughout the Health Body and is visible and accessible to staff via the consent SharePoint page.

4.3.7 There is no clear evidence provided which demonstrates that healthcare professionals can easily access and download locally developed PSPILs, e.g., in outpatient clinics. In relation to local PSPILs on consent, the Health Body plans to utilise the WRP database in the future.

4.3.8 The Health Body does not appear to have a detailed database which identifies and tracks locally developed PSPILs, recording ownership and review dates. The Consent Team save copies of any locally produced leaflets that they receive, but due to limited resource/vacancy have not had opportunity to progress this at present.

4.3.9 The Health Body does not have a process in place to identify professionally recognised PSPILs apart from those professional body leaflets available via the CanolfanEIDOCymru platform.

4.3.10 The Health Body has not evidenced a process in place to notify the WRP of locally developed PSPILs (where the Health Body wishes to deviate from the use of an EIDO / professionally recognised PSPIL, or where no EIDO leaflet or compliant alternative is available).

Compliance with Standard: Partial

4.4 Area for Assessment 4

Training

4.4.1 There are discussions in place with the Consent Lead(s) and Medical Training Manager to make arrangements for Foundation Years 1 and 2 and Resident doctors in relation to induction.

4.4.2 The Health Body has mandated training for the 3 identified categories and adopted the Decision Making and Consent in Wales training via ESR since May 2024 for the following categories of staff:

- Medical and Dental
- Nursing and Midwifery Registered
- Allied Healthcare Professionals

4.4.3 The Medical Director has assigned an individual to promote and monitor specific mandatory training, including consent, within medical workforce. The Health Board considers that the online module is the best way to obtain engagement therefore awareness of this is raised with resident doctors in core training. Training records are available via ESR.

4.4.4 The Health Body has promoted the need to undertake training on consent throughout the Health Body via its SharePoint page. Training is advertised on ESR and a screen saver on UHB computers.

4.4.5 The Health Body has identified its MCA Project Lead(s), formerly Consent Lead(s), as the current contact point for the WRP team to liaise with in relation to identification of the staff who should undertake consent training and confirmation of compliance rates.

4.4.6 The Health Body has identified on its ESR record, the relevant staff members who are required to undertake the e-Learning on consent in Wales.

4.4.7 Compliance is monitored every 6 months and as of 30th November 2025, the Health Body had achieved 79.5% compliance with consent training (Standard - 85%). This is demonstrated below:

Total staff		
Total staff to be trained in three categories	Total staff trained in three categories	%
7620	**6058**	**79.5**

Staff groups					
Total *Medical and Dental* staff to be trained	Total *Medical and Dental* staff trained	Total *Nursing and Midwifery* registered staff to be trained	Total *Nursing and Midwifery* registered staff trained	Total *Allied and Health Care* Professionals to be trained	Total *Allied and Health Care* Professionals trained
1214	**590**	**5071**	**4273**	**1335**	**1195**

4.4.8 NWSSP has recently applied the requirement for Single Lead Employer (SLE) staff to complete the consent e-Learning package. Compliance figures are currently low across NHS Wales and it is essential that colleagues in all organisations support this implementation.

4.4.9 It is unclear how the Health Body reviews and updates the numbers of staff with a requirement to undertake training.

4.4.10 The Health Body has put into place arrangements for the approval of other local training on consent in accordance with WRP guidance, via approval by the MCA Project lead, formerly Consent Lead. The lead liaises with the education department to approve compliance on ESR.

4.4.11 It is unclear how the Health Body records staff who have completed an alternative training programme to the e-Learning package so that this is correctly captured and staff are not expected to undertake two training programmes in the same period.

Compliance with Standard: Partial

4.5 Area for Assessment 5

Monitoring and Review of the Consent Policy and process, use of consent forms / PSCFs and PSPILs

4.5.1 The Health Body has not provided evidence that consent forms part of a formal Health Body wide programme for the audit / peer review of the Consent Policy and consent process, and use of consent forms / PSCFs and PSPILs.

4.5.2 The Health Body states that there are discussions underway to adopt the All Wales Peer review tool and methodology. Arrangements are underway for a review in the autumn.

4.5.3 The Consent Lead(s) has undertaken an audit across each clinical board to establish the use of the consent process and whether it is in line with the consent policy. This was also to identify the use of consent forms / PSCFs and PSPILs. Final results are not yet available.

4.5.4 The Health Body states that it undertakes ad hoc audits / peer reviews of the consent forms in use. Feedback in relation to these audits and what has been undertaken is awaited. These are noted on the Tier 3 audit plan but there is no clear methodology. There are no clear action plans and feedback of consent forms / PSCFs and PSPILs.

4.5.5 There is no evidence of organisational-wide audits / peer review being reported to a relevant Health Body Committee.

4.5.6 There is no clear governance process for every ad hoc audit / peer review which is reported to the specialty Clinical Governance Group.

4.5.7 There is no evidence that a formal action plan is created for every Health Body wide ad hoc audit / peer review.

4.5.8 There is no clear evidence that the outcomes of every Health Body wide and ad hoc audit / peer review are circulated to staff wider than the group this is reported to.

Compliance with Standard: Non-compliant

5 Assurance Rating

Having considered the evidence submitted against each Area for Assessment, the Review Team have determined an overall assurance rating of **Reasonable Assurance** for the Health Body. This utilises the NHS Wales Internal Audit Framework outlined in Appendix 2.

REASONABLE ASSURANCE		The organisation can take **reasonable assurance** that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

6 Summary and recommendations

6.1 The Health Body can take **reasonable assurance** in respect of the processes relating to Consent to Examination & Treatment. Of the 5 Areas for Assessment, the Health Body is compliant in 2 areas, is partially compliant in 2 and non-compliant with the area relating to audit.

6.2 By completing the assessments, organisations have scrutinised and interrogated their consent processes. This has enabled the teams within the Health Bodies to familiarise with the WRP Standard and identify and source evidence which demonstrates compliance or achievement against each area for assessment.

6.3 The Health Body has made some progress to align with the recommendations made in the 2023 report. In particular, the Health Body has adopted the All Wales Model Policy for Consent to Examination or Treatment and this has been formally ratified. However, there are areas identified where improvement would enhance the consent process, particularly in relation to its audit processes, and this is detailed in section 4 and is reflected in the recommendations.

6.4 Recommendations have been developed to support all Health Bodies to achieve the standards expected to enable them to enhance their consent processes. It is recognised that some organisations have already achieved some of these standards and this should be reflected when compiling their action plan (see Appendix 3) where assurance should be provided that these standards will be sustained moving forward.

6.5 Having analysed the evidence submitted the Health Body is also required to address any findings specific to the organisation. The Health Body has addressed the recommendations and these are detailed in the submitted action plan in Section 7.

Recommendations

Area for Assessment 1: Policy and Management of Decision Making and Consent to Examination and Treatment

The AWMCP for consent to examination or treatment is under review and will be ratified by the Welsh Risk Pool Committee. Alignment with the policy is integral to their standardised and quality approach to the consent process.

Recommendation 1.1

All Health Bodies are expected to adopt the AWMCP and should ensure that this is reviewed (outside of its regular 3 yearly review programme) to ensure that it is aligned to other Health Bodies in Wales.

Recommendation 1.2

All Health Bodies should have or establish a group which meets regularly where consent is a standing agenda item and features in the Terms of Reference.

Recommendation 1.3

All Health Bodies should ensure that there is a clear published pathway for staff requiring advice in relation to consent on a relevant page on the Health Body's SharePoint.

Area for Assessment 2: Consent Forms including Procedure Specific Consent Forms (PSCFs)

PSCFs provide particular benefits by enhancing the informed consent process and improving patient safety as well as reducing risk for both individual healthcare professionals and the Health Board.

The particular benefits are improved communication of the nature of the treatment or procedure as well as risks, benefits and alternatives, and standardisation of evidence-based information which is reviewed for readability and meets Welsh Language requirements. Clinical teams can agree and develop forms and implement across the Health Body, leading to standardised care delivery across the organisation and improving the efficiency of the informed consent process in out-patient clinics or treatment areas allowing more time for discussion and agreement with the patient.

Recommendation 2.1

All Health Bodies should adopt the All Wales PSCF Template which is available in both English and Welsh.

Recommendation 2.2

All Health Bodies should develop, approve and ratify one formally approved guidance document which sets out the organisation's governance process in relation to the development and approval of local PSCFs.

Recommendation 2.3

All Health Bodies should maintain a database of locally developed PSCFs which includes review dates.

Area for Assessment 3: Procedure Specific Patient Information Leaflets (PSPIL) including locally developed PSPLs

Patient information leaflets, combined with effective record keeping lead to more effective and efficient clinician-patient consultations and more robust consent processes by providing the optimum level of detail regarding risks and benefits associated with a particular procedure.

Recommendation 3.1

Where there is no EIDO or professional body equivalent leaflet in place, all Health Bodies should develop, approve and ratify one formally approved guidance document which sets out the organisation's governance process in relation to the development and approval of local PSPILs.

Recommendation 3.2

All Health Bodies should maintain a database of PSPILs used within the Health Body consent process to include details of authors and review dates.

Recommendation 3.3

All Health Bodies should have a governance process in place to advise the Once For Wales Team of locally developed leaflets where the organisation has to deviate from the use of an EIDO patient information leaflet, or where no EIDO leaflet or professional body alternative is available.

Recommendation 3.4

All Health Bodies should ensure that their SharePoint page links to CanolfanEIDO Cymru.

Area for Assessment 4: Training

Training and refresher training on consent is key to clinicians' understanding of the consent process. This training can be delivered via the gold standard training available via ESR – OOO NHS Wales – Decision Making and Consent in Wales or alternatively WRP approved training which meets the following requirements / guidance:

- The training session is at least 60 minutes in duration
- The training programme must relate to the process for obtaining consent to adults, children and young people with capacity.
- There should be reference to the Mental Capacity Act and the process for assessing capacity.
- It can be delivered in person or via a virtual platform
- It must be delivered by an expert within the topic of consent
- An example could include the GMC training on Decision making and consent or formal training delivered by legal & risk services

Recommendation 4.1

All Health Bodies should mandate the need for the following categories of staff to undertake WRP agreed training on consent and refresh that training every 3 years:

- *Medical and Dental*
- *Nursing and Midwifery Registered*
- *Allied Healthcare Professionals*

Recommendation 4.2

All Health Bodies should adopt and promote the new All Wales Induction programme video on Decision Making and Consent in Wales which also directs staff to the 000 NHS-Wales Decision Making and Consent in Wales available via ESR.

Recommendation 4.3

All Health Bodies should promote the requirement for SLE staff to undertake the Mandatory training on 000 NHS-Wales - Decision Making and Consent in Wales.

Recommendation 4.4

All Health Bodies who provide alternate ad hoc training on consent should establish a clear process to record attendance so staff are not expected to undertake two training programmes in the same period.

Area for Assessment 5: Monitoring and Review of the Consent Policy and process, use of consent forms / PSCFs and PSPILs

Audit and peer review enables Health Bodies to monitor compliance with the consent process and address any shortfalls in the use, provision of, and documentation of patient information leaflets.

Recommendation 5.1

All Health Bodies should continue to undertake a review of the organisation's consent process on a Health Body wide and ad hoc basis.

Recommendation 5.2

Audit findings for Health Body wide and ad hoc peer reviews / audits should be formally reported at Board level or an appropriate sub-committee and every effort made to act on the shortfalls identified in the reports.

Recommendation 5.3

All Health Bodies should have clear processes in place to monitor and address any shortfalls in the consent process and the use, provision of, and documentation of patient information leaflets and address any shortfalls at a strategic and specialty level.

Recommendation 5.4

All Health Bodies should have a clear process which demonstrates how it provides feedback on the audit results to both individuals and more generically in order to initiate the improvements.

7 Health Body's Action Plan

Recommendation	Action	Date for completion	RAG Status	Responsibility
Area for Assessment 1: Policy and Management of Decision Making and Consent to Examination and Treatment				
1.1 All Health Bodies are expected to adopt the AWMCP and should ensure that this is reviewed (outside of its regular 3 yearly review programme) to ensure that it is aligned to other Health Bodies in Wales.	**AWMCP reviewed every 3 years and takes account of updates from All Wales Group. Ad hoc changes made where it is identified that guidance or best practice has changed/updated.**	**Ongoing**		**MCA Project Lead / Consent Lead**
1.2 All Health Bodies should have or establish a group which meets regularly where consent is a standing agenda item and features in the Terms of Reference.	**CAV Consent Group meets bi-monthly** **ToR attached**	**Completed**		**MCA Project Lead**
1.3 All Health Bodies should ensure that there is a clear published pathway for staff requiring advice in relation to consent on a relevant page on the Health Body's SharePoint.	**Contact detail for Consent Lead on SharePoint outlining areas for support i.e. advice and guidance, training, review of documents, escalation/referral to legal**	**Completed**		**MCA Project Lead / Consent Lead**
Area for Assessment 2: Consent Forms including Procedure Specific Consent Forms (PSCFs)				
2.1 All Health Bodies should adopt the All Wales PSCF Template which is available in both English and Welsh.	**Already in place adopted in November 2024**	**Completed**		**MCA Project Lead / Consent Lead**
2.2 All Health Bodies should develop, approve and ratify one formally approved guidance document which sets out the organisation's governance process in relation to the development and approval of local PSCFs.	**Already in place and published on SharePoint policies pages – due for review December 2027**	**Completed**		**MCA Project Lead / Consent Lead**
2.3 All Health Bodies should maintain a database of locally developed PSCFs which includes review dates.	**Managed by medical illustration – also PSCFs go through the team following review by Consent Lead. MI maintain database and manage**	**Ongoing**		**Nominated lead RE in Medical Illustration**

	version control, printing carbonated copies etc.			
Area for Assessment 3: Procedure Specific Patient Information Leaflets (PSPIL) including locally developed PSPLs				
3.1 Where there is no EIDO or professional body equivalent leaflet in place, all Health Bodies should develop, approve and ratify one formally approved guidance document which sets out the organisation's governance process in relation to the development and approval of local PSPILs.	**Already in place and available on SharePoint policies page – due for review October 2027**	**Completed**		**MCA Project Lead / Consent Lead**
3.2 All Health Bodies should maintain a database of PSPILs used within the Health Body consent process to include details of authors and review dates.	**Use of PSPIL audit tool, to gain feedback of patient information leaflets used in each speciality outside of EIDO – with view to mirror process used in HDUHB – Vascular example**.	**January 2027**		**Consent Lead and Relevant Specialty leads**
3.3 All Health Bodies should have a governance process in place to advise the Once For Wales Team of locally developed leaflets where the organisation has to deviate from the use of an EIDO patient information leaflet, or where no EIDO leaflet or professional body e alternative is available.	**Use of EIDO function to develop database of patient information leaflets in use within CAVUHB following PSPIL audit, as above.**	**January 2027**		**Consent Lead / Relevant Specialities**
Area for Assessment 4: Training				
4.1 All Health Bodies should mandate the need for the following categories of staff to undertake WRP agreed training on consent and refresh that training every 3 years: ▪ Medical and Dental ▪ Nursing and Midwifery Registered ▪ Allied Healthcare Professionals	**Mandated since August 2024**	**Completed**		**MCA Project Lead / Consent Lead**
4.2 All Health Bodies should adopt and promote the new All Wales Induction programme video on Decision Making and Consent in Wales which also directs staff to the 000 NHS-Wales Decision Making and Consent in Wales available via ESR.	**Shared at CAV Consent Group (April 2026).** **To also be communicated across UHB via:** - **SharePoint Consent page** - **Screensaver** - **Consent Newsletter**	**September 2026**		**MCA Project Lead / Consent Lead**

4.3 All Health Bodies should promote the requirement for Single Lead Employer staff to undertake the Mandatory training on 000 NHS-Wales Decision Making and Consent in Wales.	**Poster circulated via email (March 2026) and shared with medical education team.** **To be advertised by way of screensaver across UHB computers.**	**September 2026**		**MCA Project Lead / Consent Lead,**
4.4 All Health Bodies who provide alternate ad hoc training on consent should establish a clear process to record attendance so staff are not expected to undertake two training programmes in the same period.	**- Staff who attend face to face consent training provided by Consent Lead also have their record updated on ESR.** **For staff who have attend other non-UHB consent training, this can be honoured where there is evidence that it meets the requirements set by WRP. Evidence should be provided to Consent Lead for review.** **- To identify if there are other consent training offerings that are routinely used by professionals which would achieve required competence and outline means to identify and record this on ESR profiles.**	**Ongoing**		**Consent Lead / MCA Team Administrator / ECOD / Medical Education**
Area for Assessment 5: Monitoring and Review of the Consent Policy and process, use of consent forms / PSCFs and PSPILs				
5.1 All Health Bodies should continue to undertake a review of the organisation's consent process on a Health Body wide and ad hoc basis.	**Develop and implement a Health Board-wide consent review programme, including an agreed annual audit schedule and a process for ad hoc reviews where concerns, incidents, complaints, claims, peer review findings or service changes indicate potential shortfalls in consent practice.**	**March 2027, then ongoing annual review and ad hoc review as required**		**Specialty Governance Leads/Clinical audit dept/Associate Medical Director Patient Safety/Executive Medical Director**

	Findings to be reported through the CAV Consent Group and relevant Clinical Board Quality and Safety governance routes, with improvement actions monitored to completion			
5.2 Audit findings for Health Body wide and ad hoc peer reviews / audits should be formally reported at Board level or an appropriate sub-committee and every effort made to act on the shortfalls identified in the reports.	**Report outlining findings of peer reviews to be shared at Quality Committee and CAV Consent Group.**	**As required**		**Relevant leads/ aud**
5.3 All Health Bodies should have clear processes in place to monitor and address any shortfalls in the consent process and the use, provision of, and documentation of patient information leaflets and address any shortfalls at a strategic and specialty level.	**Implement a standardised consent and PSPIL audit process across specialties, with findings reported to specialty Quality and Safety meetings and the CAV Consent Group. Identified shortfalls to be recorded on specialty action plans, escalated where required, and monitored through to completion**	**March 2027, then ongoing quarterly monitoring**		**Consent Lead / Clinical Board Quality & Safety Leads / Specialty Governance Lead/ Associate Medical Director Patient Safety/Executive Medical Director**
5.4 All Health Bodies should have a clear process which demonstrates how it provides feedback on the audit results to both individuals and more generically in order to the improvements.	**Implement a structured consent audit feedback process, including individual feedback to clinicians, themed reporting to Clinical Board Quality and Safety meetings and the CAV Consent Group, and wider dissemination of learning via SharePoint, newsletters and training. Evidence of feedback and improvements to be recorded and monitored.**	**March 2027**		**Consent Lead / Clinical Board Quality & Safety Leads / Specialty Governance Leads**

Appendix 1

Welsh Risk Pool (WRP) Assessment Tool – Decision Making and Consent (Consent)

WRP Decision Making and Consent Assessment – Areas for Assessment – 2025 - 2026

The WRP Assessment Programme uses a series of Areas for Assessment to guide the Assessment Team in the aspects and criteria to be examined. These cover the areas of activity which directly impact on the Decision Making and Consent to Examination and Treatment (Consent) process in NHS Health Bodies in Wales and which may lead to a request for reimbursement from the WRP. The Areas for Assessment provide a framework for the Assessment Team to gather information, evidence and collate data to support the identification of findings and the establishment of recommendations.

This guidance outlines the matters and information included in each of the Areas for Assessment.

There are **five** Areas for Assessment:

Area for Assessment 1	Policy and Management of Decision Making and Consent to Examination and Treatment
Area for Assessment 2	Consent Forms including Procedure Specific Consent Forms (PSCFs)
Area for Assessment 3	Procedure Specific Patient Information Leaflets (PSPIL) including locally developed PSPLs
Area for Assessment 4	Training
Area for Assessment 5	Monitoring and Review of the Consent Policy and process, use of consent forms / PSCFs and PSPILs

Area for Assessment	Guidance
Area for Assessment 1 **Policy and Management of Consent to Examination and Treatment**	There is an organisational wide policy for obtaining informed consent, which, at a minimum, is the All-Wales Model Policy for Consent to Examination or Treatment. The requirements in this area necessitate that there is specific advice for those staff who are responsible for providing informed consent in sometimes difficult circumstances covering at the very least: • Documentation • When consent should be sought • Provision of information • Who is responsible for seeking consent • Adults with capacity – refusal of treatment • Treatment of children and young people • Patients who lack capacity to give or withhold consent • Human tissue • Clinical photography, video recordings and audio recordings • Consent to specific procedures • Seeking consent for genetic investigations (or investigations likely to reveal the diagnosis as being a genetic disorder) • Withholding or withdrawing life sustaining treatment • Medical treatment of patients with a mental disorder • Consent to research and innovative treatment • Training • Consent in obstetrics and gynaecology • Treatment in a mental health setting Health Bodies may also develop additional polices / guidance to support the Model Policy e.g. Mental Capacity Act, Jehovah's Witness or Children. Health Bodies should ensure that Decision Making & Consent has a clear profile, with its own Group meeting regularly or as part of another Group's standing agenda item. Health Bodies should have clear sources of support for staff seeking advice upon issues which arise in relation to consent

Area for Assessment 2 **Consent Forms including Procedure Specific Consent Forms (PSCFs)**	All consent forms – All Wales Consent Forms 1, 2 and Form 4 and PSCFs used within the organisation should be current, follow the format outlined within the guidance and are compliant with Welsh Language Standards. Locally developed PSCFs should be developed in accordance with clear local governance arrangements, using a recognised template.
Area for Assessment 3 **Procedure Specific Patient Information Leaflets (PSPIL) including locally developed PSPLs**	PSPI should illustrate the risk, benefits and alternatives of common elective treatments, which have also been translated into languages other than English and Welsh (dependant on population profile). Where the NHS organisation does not undertake surgery, evidence of the provision of patient information for procedures and interventions should still be available. It is important to ensure that PSPI provided for patients is relevant, accurate and up to date. The minimum standard is the use of the EIDO Healthcare published PSPILs facilitated through the all-Wales download centre or professionally recognised PSPILs including leaflets from the Royal Colleges or Professional Associations, NICE, Cancer Research UK and MacMillan Where an organisation is not utilising EIDO or professionally recognised PSPILs, there should be clear responsibility and a governance process for ensuring that there is a need to develop a local PSPIL, final approval and that it meets specific criteria governing: • The topics that should be covered; • The evidence-base; • The regularity of review. Further detail is given in the following WRP alert WRP Risk management Alert RMA 2020-01- Consent to Examination and Treatment and Update 3rd December2020.
Area for Assessment 4 **Training on Decision Making and Consent**	Training must be provided regularly on consent and the education programmes should include the assessment of mental capacity. Training should be provided at induction and to all other appropriate staff groups.

	There is a consensus to require all registered healthcare professionals to undertake the training. This includes the following categories of staff: • Medical & Dental • Nursing & Midwifery Registered • Allied Health Professionals This is a minimum standard and all other Healthcare Professionals involved in all aspects of the consent process (not just those obtaining written consent) should be encouraged to undertake training on consent. The gold standard training for Wales is the e-learning entitled – 'Deciosn Making and Consent in Wales' which is available on ESR and Learning@Wales - more detailed information can be accessed here. Those who undertake this training via ESR or Learning@Wales will automatically register their compliance. Those undertaking local training can do so, and the following guidance has been given by the WRP – • The training session is at least 60 minutes in duration • The training programme must relate to the process for obtaining consent to adults, children and young people with capacity. • There should be reference to the Mental Capacity Act and the process for assessing capacity. • It can be delivered in person or via a virtual platform • It must be delivered by an expert within the topic of consent - An example could include the GMC training on Decision making and consent or formal training delivered by legal & risk services • Arrangements must be in place to ensure alternative local training on consent meet these requirements • Arrangements will have to be in place to register those who have undertaken local training in this way

	The WRP has issued a number of requirements of Health Bodies to assist in monitoring compliance with training as identified in Appendix 4 – AA4 below. The target compliance rate should be 85%, which is similar to other training of this nature. The actual participation rate is included as a metric within the WRP Risk Sharing Agreement.
Area for Assessment 5 **Monitoring and Review of the Consent Policy and process, use of consent forms / PSCFs and PSPILs**	There is evidence that the Health Body's Consent policy, agreed consent forms and PILs are being applied and used correctly throughout the organisation. This can be done by peer review of the consent process and records, utilising, for example the gold standard peer review tool developed on an All-Wales basis with accompanying methodology. Other audits / peer reviews can also be facilitated to e.g. review completion of consent forms Health Bodies should hold an action plan to monitor and address any identified issues in the consent process and feedback following peer-reviews and audits should be provided to both individuals and across the organisation to help coordinate improvements.

Appendix 2

NHS Wales Assurance Framework

SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.
REASONABLE ASSURANCE		The organisation can take **reasonable assurance** that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.
LIMITED ASSURANCE		The organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.
NO ASSURANCE		The organisation has **no assurance** that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. Action is required to address the whole control framework in this area with high impact on residual risk exposure until resolved.

Appendix 3

Action Plan Template

Recommendation	Action	Date for completion	RAG Status	Responsibility
Area for Assessment 1: Policy and Management of Decision Making and Consent to Examination and Treatment				
1.1 All Health Bodies are expected to adopt the AWMCP and should ensure that this is reviewed (outside of its regular 3 yearly review programme) to ensure that it is aligned to other Health Bodies in Wales.				
1.2 All Health Bodies should have or establish a group which meets regularly where consent is a standing agenda item and features in the Terms of Reference.				
1.3 All Health Bodies should ensure that there is a clear published pathway for staff requiring advice in relation to consent on a relevant page on the Health Body's SharePoint.				
Area for Assessment 2: Consent Forms including Procedure Specific Consent Forms (PSCFs)				
2.1 All Health Bodies should adopt the All Wales PSCF Template which is available in both English and Welsh.				
2.2 All Health Bodies should develop, approve and ratify one formally approved guidance document which sets out the organisation's governance process in relation to the development and approval of local PSCFs.				
2.3 All Health Bodies should maintain a database of locally developed PSCFs which includes review dates.				

Area for Assessment 3: Procedure Specific Patient Information Leaflets (PSPIL) including locally developed PSPLs				
3.1 Where there is no EIDO or professional body equivalent leaflet in place, all Health Bodies should develop, approve and ratify one formally approved guidance document which sets out the organisation's governance process in relation to the development and approval of local PSPILs.				
3.2 All Health Bodies should maintain a database of PSPILs used within the Health Body consent process to include details of authors and review dates.				
3.3 All Health Bodies should have a governance process in place to advise the Once For Wales Team of locally developed leaflets where the organisation has to deviate from the use of an EIDO patient information leaflet, or where no EIDO leaflet or professional body e alternative is available.				
Area for Assessment 4: Training				
4.1 All Health Bodies should mandate the need for the following categories of staff to undertake WRP agreed training on consent and refresh that training every 3 years: ▪ Medical and Dental ▪ Nursing and Midwifery Registered ▪ Allied Healthcare Professionals				
4.2 All Health Bodies should adopt and promote the new All Wales Induction programme video on Decision Making and Consent in Wales which also directs staff to the 000 NHS-Wales Decision Making and Consent in Wales available via ESR.				
4.3 All Health Bodies should promote the requirement for Single Lead Employer staff to undertake the Mandatory training on 000 NHS-Wales Decision Making and Consent in Wales.				
4.4 All Health Bodies who provide alternate ad hoc training on consent should establish a clear process to record attendance				

so staff are not expected to undertake two training programmes in the same period.				
Area for Assessment 5: Monitoring and Review of the Consent Policy and process, use of consent forms / PSCFs and PSPILs				
5.1 All Health Bodies should continue to undertake a review of the organisation's consent process on a Health Body wide and ad hoc basis.				
5.2 Audit findings for Health Body wide and ad hoc peer reviews / audits should be formally reported at Board level or an appropriate sub-committee and every effort made to act on the shortfalls identified in the reports.				
5.3 All Health Bodies should have clear processes in place to monitor and address any shortfalls in the consent process and the use, provision of, and documentation of patient information leaflets and address any shortfalls at a strategic and specialty level.				
5.4 All Health Bodies should have a clear process which demonstrates how it provides feedback on the audit results to both individuals and more generically in order to the improvements.				

Cardiff and Vale University Health Board

Action Plan in response to recommendations arising from the 2025/26 National Review of Decision Making and Consent to Examination & Treatment Standards in NHS Wales

Recommendation	Action	Date for completion	RAG Status	Responsibility
Area for Assessment 1: Policy and Management of Decision Making and Consent to Examination and Treatment				
1.1 All Health Bodies are expected to adopt the AWMCP and should ensure that this is reviewed (outside of its regular 3 yearly review programme) to ensure that it is aligned to other Health Bodies in Wales.	**AWMCP reviewed every 3 years and takes account of updates from All Wales Group. Ad hoc changes made where it is identified that guidance or best practice has changed/updated.**	**Ongoing**		**MCA Project Lead / Consent Lead**
1.2 All Health Bodies should have or establish a group which meets regularly where consent is a standing agenda item and features in the Terms of Reference.	**CAV Consent Group meets bi-monthly** **ToR attached**	**Completed**		**MCA Project Lead**
1.3 All Health Bodies should ensure that there is a clear published pathway for staff requiring advice in relation to consent on a relevant page on the Health Body's SharePoint.	**Contact detail for Consent Lead on Sharepoint outlining areas for support i.e. advice and guidance, training, review of documents, escalation/referral to legal**	**Completed**		**MCA Project Lead / Consent Lead**
Area for Assessment 2: Consent Forms including Procedure Specific Consent Forms (PSCFs)				
2.1 All Health Bodies should adopt the All Wales PSCF Template which is available in both English and Welsh.	**Already in place adopted in November 2024**	**Completed**		**MCA Project Lead / Consent Lead**
2.2 All Health Bodies should develop, approve and ratify one formally approved guidance document which sets out the organisation's governance process in relation to the development and approval of local PSCFs.	**Already in place and published on Sharepoint policies pages – due for review December 2027**	**Completed**		**MCA Project Lead / Consent Lead**
2.3 All Health Bodies should maintain a database of locally developed PSCFs which includes review dates.	**Managed by medical illustration – also PSCFs go through the team following review by Consent Lead.**	**Ongoing**		**Nominated lead RE in Medical Illustration**

	MI maintain database and manage version control, printing carbonated copies etc.			
Area for Assessment 3: Procedure Specific Patient Information Leaflets (PSPIL) including locally developed PSPLs				
3.1 Where there is no EIDO or professional body equivalent leaflet in place, all Health Bodies should develop, approve and ratify one formally approved guidance document which sets out the organisation's governance process in relation to the development and approval of local PSPILs.	**Already in place and available on Sharepoint policies page – due for review October 2027**	**Completed**		**MCA Project Lead / Consent Lead**
3.2 All Health Bodies should maintain a database of PSPILs used within the Health Body consent process to include details of authors and review dates.	**Use of PSPIL audit tool, to gain feedback of patient information leaflets used in each speciality outside of EIDO – with view to mirror process used in HDUHB – Vascular example**.	**January 2027**		**Consent Lead and Relevant Specialty leads**
3.3 All Health Bodies should have a governance process in place to advise the Once For Wales Team of locally developed leaflets where the organisation has to deviate from the use of an EIDO patient information leaflet, or where no EIDO leaflet or professional body e alternative is available.	**Use of EIDO function to develop database of patient information leaflets in use within CAVUHB following PSPIL audit, as above.**	**January 2027**		**Consent Lead / Relevant Specialities**
Area for Assessment 4: Training				
4.1 All Health Bodies should mandate the need for the following categories of staff to undertake WRP agreed training on consent and refresh that training every 3 years: ▪ Medical and Dental ▪ Nursing and Midwifery Registered ▪ Allied Healthcare Professionals	**Mandated since August 2024**	**Completed**		**MCA Project Lead / Consent Lead**
4.2 All Health Bodies should adopt and promote the new All Wales Induction programme video on Decision Making and	**Shared at CAV Consent Group (April 2026).**	**September 2026**		**MCA Project Lead / Consent Lead**

Consent in Wales which also directs staff to the 000 NHS-Wales Decision Making and Consent in Wales available via ESR.	**To also be communicated across UHB via:** - **Sharepoint Consent page** - **Screensaver** - **Consent Newsletter**			
4.3 All Health Bodies should promote the requirement for Single Lead Employer staff to undertake the Mandatory training on 000 NHS-Wales Decision Making and Consent in Wales.	**Poster circulated via email (March 2026) and shared with medical education team.** **To be advertised by way of screensaver across UHB computers.**	**September 2026**		**MCA Project Lead / Consent Lead,**
4.4 All Health Bodies who provide alternate ad hoc training on consent should establish a clear process to record attendance so staff are not expected to undertake two training programmes in the same period.	**- Staff who attend face to face consent training provided by Consent Lead also have their record updated on ESR.** **For staff who have attend other non-UHB consent training, this can be honoured where there is evidence that it meets the requirements set by WRP. Evidence should be provided to Consent Lead for review.** **- To identify if there are other consent training offerings that are routinely used by professionals which would achieve required competence and outline means to identify and record this on ESR profiles.**	**Ongoing**		**Consent Lead / MCA Team Administrator / ECOD / Medical Education**
Area for Assessment 5: Monitoring and Review of the Consent Policy and process, use of consent forms / PSCFs and PSPILs				
5.1 All Health Bodies should continue to undertake a review of the organisation's consent process on a Health Body wide and ad hoc basis.	**Develop and implement a Health Board-wide consent review programme, including an agreed annual audit schedule and a process for ad hoc reviews where concerns,**	**March 2027, then ongoing annual review and ad hoc**		**Specialty Governance Leads/Clinical audit dept/Associate**

	incidents, complaints, claims, peer review findings or service changes indicate potential shortfalls in consent practice. **Findings to be reported through the CAV Consent Group and relevant Clinical Board Quality and Safety governance routes, with improvement actions monitored to completion**	**review as required**		**Medical Director Patient Safety/Executive Medical Director**
5.2 Audit findings for Health Body wide and ad hoc peer reviews / audits should be formally reported at Board level or an appropriate sub-committee and every effort made to act on the shortfalls identified in the reports.	**Report outlining findings of peer reviews to be shared at Quality Committee and CAV Consent Group.**	**As required**		**Relevant leads/ aud**
5.3 All Health Bodies should have clear processes in place to monitor and address any shortfalls in the consent process and the use, provision of, and documentation of patient information leaflets and address any shortfalls at a strategic and specialty level.	**Implement a standardised consent and PSPIL audit process across specialties, with findings reported to specialty Quality and Safety meetings and the CAV Consent Group. Identified shortfalls to be recorded on specialty action plans, escalated where required, and monitored through to completion**	**March 2027, then ongoing quarterly monitoring**		**Consent Lead / Clinical Board Quality & Safety Leads / Specialty Governance Lead/ Associate Medical Director Patient Safety/Executive Medical Director**
5.4 All Health Bodies should have a clear process which demonstrates how it provides feedback on the audit results to both individuals and more generically in order to the improvements.	**Implement a structured consent audit feedback process, including individual feedback to clinicians, themed reporting to Clinical Board Quality and Safety meetings and the CAV Consent Group, and wider dissemination of learning via SharePoint, newsletters and training. Evidence of feedback and improvements to be recorded and monitored.**	**March 2027**		**Consent Lead / Clinical Board Quality & Safety Leads / Specialty Governance Leads**

Cardiff and Vale University Health Board

Consent

Report summary, key themes and actions

27 October 2026

Agenda item 8.1

Key themes from the report

Reasonable assurance, with clear gaps to address

Assurance and ownership	Policy and consent forms are compliant. Monitoring and review is the principal assurance gap.
Staff capability	Overall training exceeds 85%, but Medical and Dental compliance remains at 61.9%.
Patient understanding and access	Extend approved information and retain accessible alternatives as digital consent develops.
Evidence of improvement	Combine audit findings with incidents, complaints and claims, then track actions to completion.

WRP review: reasonable assurance

Reasonable Assurance

Welsh Risk Pool review
30 September 2026

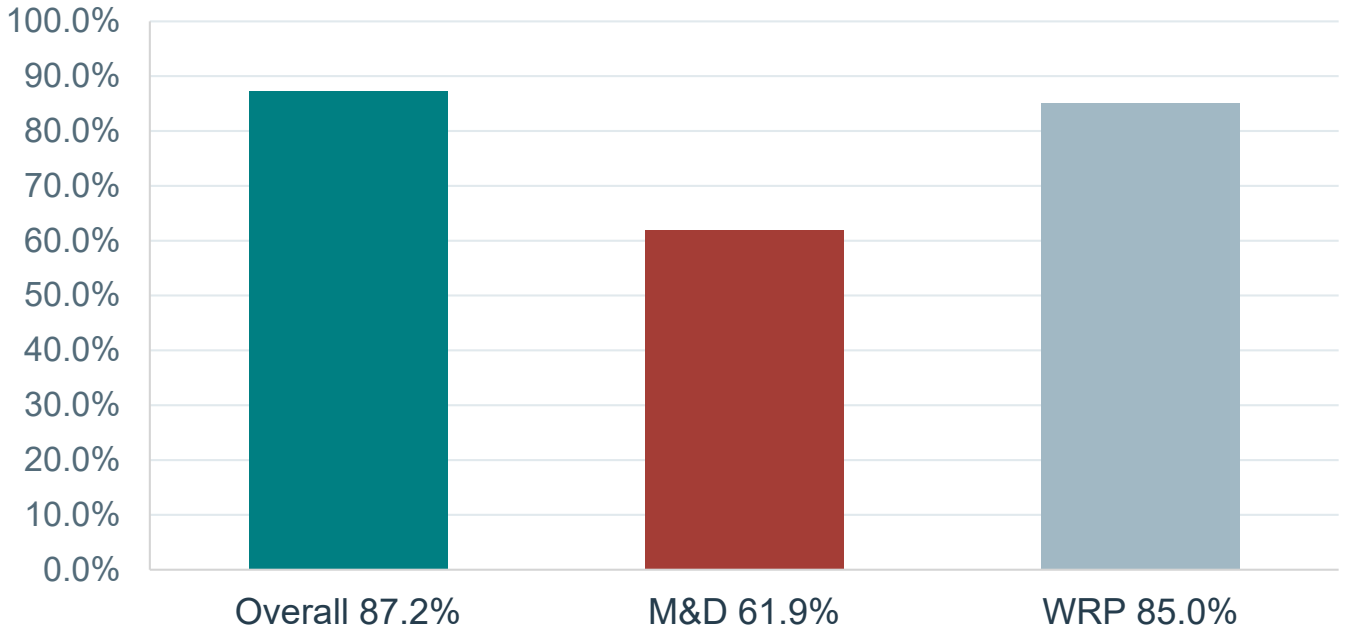
Monitoring and review remains the principal outstanding assurance gap.

Assessment area	WRP rating
1 Policy and management	**Compliant**
2 Consent forms	**Compliant**
3 Patient information leaflets	**Partially compliant**
4 Training	**Partially compliant**
5 Monitoring and review	**Non-compliant**

Ratings reflect the 2025/26 WRP review.

Medical and Dental training is below standard

At 30 September 2026. M&D = Medical and Dental



23.1 percentage points below the 85% standard

Clinical ownership

Strengthen Medical and Dental representation in the Consent Group.

Verified completion

Promote training and record approved alternatives consistently on ESR.

Targeted follow-up

Use audit, incidents, complaints and claims to guide further education.

Consent assurance programme

March 2027

Annual audit schedule, targeted reviews and the All Wales peer-review methodology

01	**Dialogue**	Time, information, questions, values and individual priorities
02	**Risks and alternatives**	Benefits, material risks, reasonable alternatives and no treatment
03	**Capacity and support**	Capacity, best interests, parental responsibility and communication support
04	**Forms and confirmation**	Approved forms, correct completion and confirmation after an interval
05	**Accessible information**	Current approved leaflets in the preferred language and accessible format

Patient information: use and oversight

EIDO is established.
Use remains variable.

Governance and coverage

Complete the Health Board-wide leaflet inventory and audit by April 2027.

Review new local leaflets before approval and extend approved information to more clinical areas.

Improvement work

Anaesthetic pre-assessment: pilot QR-code access, with printed and accessible alternatives.

Cardiac services: proposed expansion of EIDO procedure coverage.

The eConsent pilot needs agreed safeguards

General surgery

Preparations are underway for an EIDO eConsent pilot.

Earlier information, recorded questions and a clear audit trail

Information governance

Agree how the pilot handles patient information.

Clinical safety and records

Confirm safe operation and records-management arrangements.

Experience and evaluation

Define patient and staff measures before wider implementation.

Access and adjustments

Keep non-digital routes and reasonable adjustments available.

Clinician–patient dialogue remains central to valid consent.

Delivery milestones and reporting

March 2027

Health Board-wide consent assurance programme

April 2027

Patient information leaflet inventory and audit

Consent Lead

Leads action-plan delivery, with named owners and dates for audit actions.

Consent Group

Receives bi-monthly training reports and oversees operational progress.

Quality Committee

Receives assurance reports on residual risk, overdue actions and evidence of improvement.

Priority actions and responsibilities

Action	Lead / partners	Timing in report
Review policy and strengthen clinical representation	Consent Lead / Consent Group	**Under way; no deadline stated**
Raise Medical and Dental training compliance	Consent Lead / Deputy Executive Medical Director	**Immediate actions; bi-monthly reporting**
Establish consent audit and assurance programme	Consent Lead / Clinical Audit / Clinical Boards	**By March 2027**
Complete patient-information leaflet inventory and audit	Consent Lead	**By April 2027**
Agree safeguards and evaluate general-surgery eConsent pilot	General surgery / relevant governance teams*	**Before wider implementation**

*Pilot delivery roles summarise the functions involved; the report does not name a single accountable owner.

Committee request and continuing assurance

The Committee is asked to note the contents of the paper.

Residual risks

Invalid consent and missed capacity needs can compromise patient safety and access.

Claims may expose the Health Board to costs that WRP does not reimburse.

Next-report priorities

Medical and Dental training compliance.

Delivery of the monitoring programme and leaflet audit.

Overdue actions and evidence of improvement.

Report Title:	MCA and DoLS Monitoring Report		Agenda Item No:		8.2
Meeting:	Quality Committee	Public	X		27.10.2026
		Private			
Lead Executive Title:	Executive Nurse Director				
Report Author/s Title:	MCA Project Lead				

Report Focus Summary – **AAA Framework:**

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

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

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

The Committee is advised that MCA mandatory training compliance has continued to decline across professional groups, although Clinical Board action plans are in place and compliance is monitored monthly through Directors of Nursing and bimonthly through the MCA Focus Group and Safeguarding Steering Group. The impact of these actions is expected to become clearer by the end of the next quarter.

Following the AGNI judgment, DoLS referrals reduced from 522 in Q1 to 337 in Q2. The waiting list reduced from 59 to 11 and the average time awaiting BIA allocation reduced from 13 to 4 days, supported by strengthened referral review, targeted communications and weekly update training.

IMCA referrals were 55% lower than the comparable period last year, with the reduction in section 39D support reflecting fewer DoLS authorisations. The reason for the reduction in long-term accommodation referrals remains unclear and will require continued monitoring.
The MCA Team is operating at reduced capacity until April 2027; queries continue to be managed on a prioritised basis, but response times may be slower. Implementation of the All-Wales Advocacy contract has also moved from 1 January to 1 April 2027.

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

The Quality Committee is asked to:

1. NOTE the Q2 position for MCA and DoLS activity, including the impact of the AGNI judgment, the reduction in referrals and waiting times, and the continued monitoring of IMCA referral trends.
2. NOTE the decline in mandatory MCA training compliance and RECEIVE a further update on the impact of Clinical Board action plans, including areas of continuing non-compliance, at the next reporting cycle.
3. NOTE the mitigations in place for reduced MCA Team capacity and the revised implementation date of 1 April 2027 for the All Wales Advocacy contract.

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

***Where** it's been:*	Safeguarding Steering Group
***When** it went:*	15.09.2026
***What** decision was made:*	Reporting to Quality Committee

Main Report
Background & Current Situation

The purpose of this report is to provide the Quality Committee with oversight of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) activity for July to September 2026, including referral and assessment trends, mandatory and practitioner-led training, delivery of Clinical Board action plans, and the operational impact of the Supreme Court AGNI judgment. The report highlights the principal areas requiring continued monitoring and the actions being taken to support legal compliance, safe practice and organisational learning.

The MCA indicators provide a level of detail on the provision of IMCA services and the MCA activity and training compliance across the UHB, over the last quarter; along with details of the additional training and support provided by the MCA Team.

The DoLS indicators provide an overview of the last quarter's applications and assessments.

Following a Supreme Court judgement handed down on 2 June, which changed the definition of what amounts to a deprivation of liberty within UK law; it is expected that DoLS referral rates will significantly reduce however, it is likely that it will take time to see to see the full effect of this.

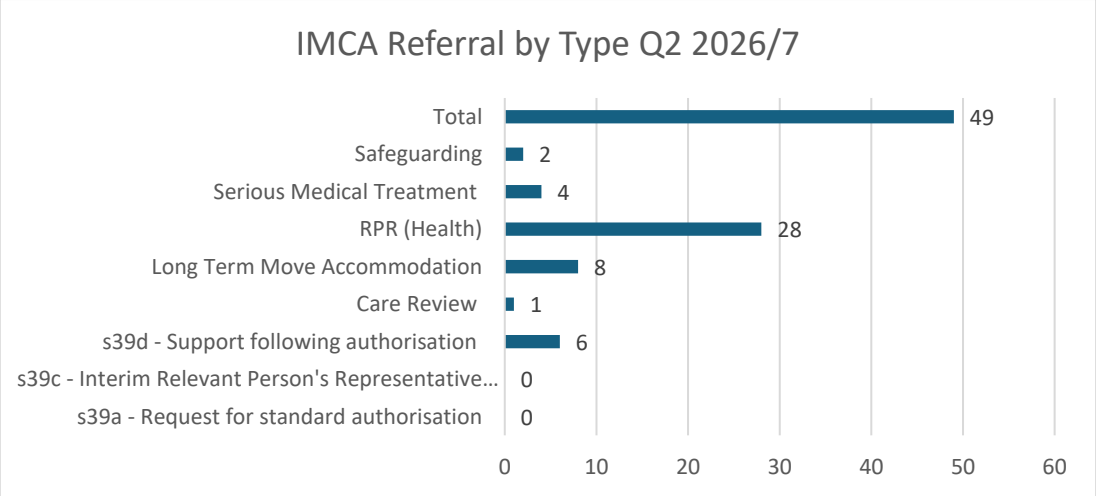
For awareness, the UHB is currently engaging in the tender process for and All Wales Advocacy contract. The target for implementation was 1st January 2027 however; due to unforeseen delays this is has now been delayed until 1st April 2027.

Mental Capacity Act Monitoring Actions (April – June 2026):

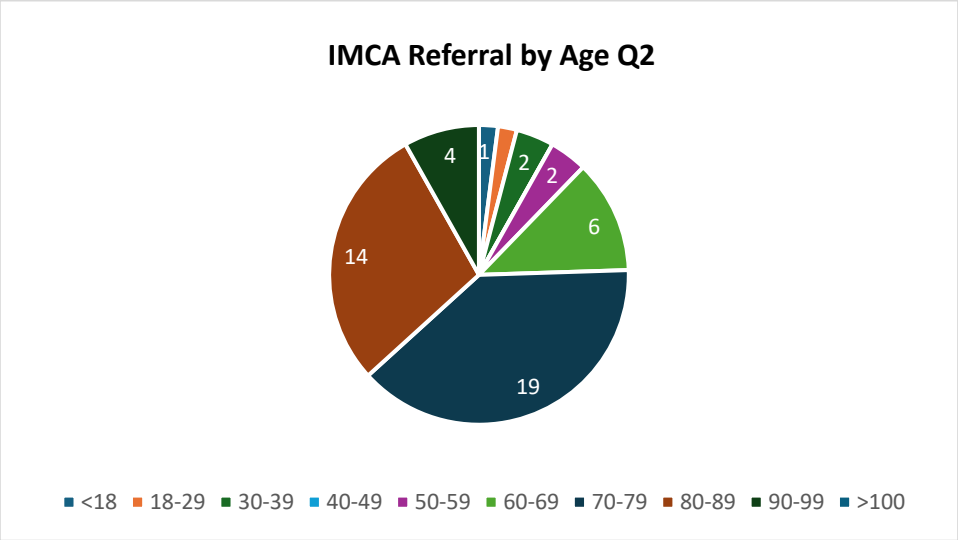
Mental Capacity IMCA Referral type

The MCA Indicators outline the breakdown of IMCA referrals for the period from July to September 2026.

Overall referral rates for this quarter are noted to be much lower than this time last year, down 55%. The biggest reduction in referral relate to long term move of accommodation and 39d for support following authorisation. The reduction in referrals for long term moves of accommodation is unclear however, the significant downturn in referrals for 39d support are a direct reflection of the reduction in the number of DoLS authorisations being granted following the changes introduced as a result of the AGNI judgment in June 2026. For other types of referral, numbers remain fairly similar taking into account the overall reduction in referral rates.



The below pie chart provides a breakdown of referrals for the last quarter by age. The majority of referrals were for people aged 60-89 (80%), with those over 60 making up for 88% of referrals overall.



In terms of language and communication needs, 98% of referrals cited English as the individual's preferred language and 2% Other Spoken Language.

Awareness Raising / Training Sessions

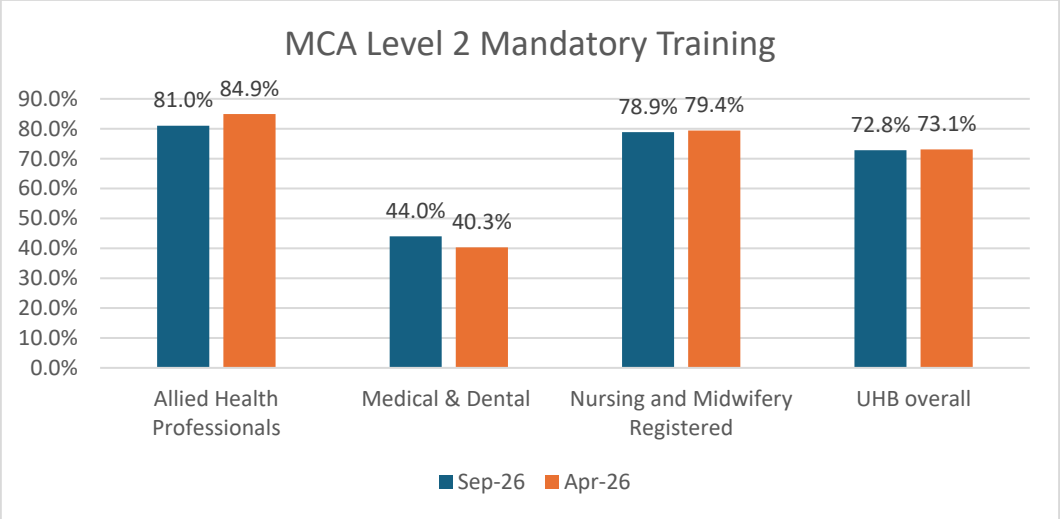
Advocacy Support Cymru continue to offer informal training sessions when visiting patient areas, with 37 sessions delivered across UHW (8), UHL (11), St David's Hospital (2) and care homes (16).

Mental Capacity Training

Mandatory MCA Training

The following graph provides a comparison of overall compliance by staff group from April to September 2026. There continues to be a slight downturn in compliance across all professional groups. The MCA team continue to raise awareness of the importance of compliance with mandatory training at every opportunity. Further, the Level 2 competency has now been added to the 'Practical Application: Mental Capacity Assessment' training, which is now delivered over a full day.

Training compliance for each clinical board is shared with the Directors of Nursing on a monthly basis and is also reported bimonthly at the MCA Focus Group and Safeguarding Steering Group. It is expected that compliance will improve following implementation of clinical board action plans, but it is anticipated that it may take until the end of the next quarter to see the impact of this.



<u>MCA Practitioner led training</u>

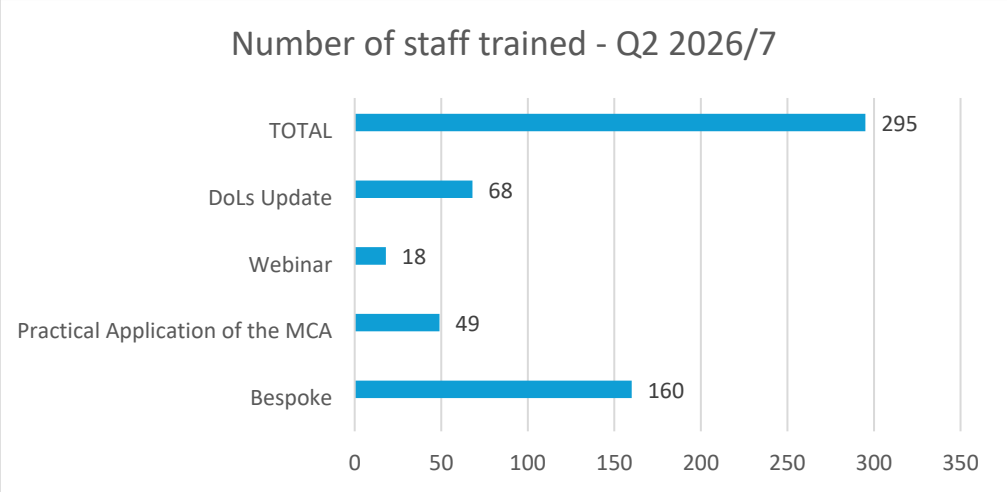
DoLS in Practice:
This training was placed on hold from June 2026 following the Supreme Court judgement and interim arrangements are underway to provide 'Update' training via Teams in order to reach a wider audience in a timely way. Sessions have been delivered weekly throughout September and October and extended accordingly.

Practical Application: Mental Capacity Assessment:
As outlined above, this training was extended from a half day to a full day training, from June 2026, to allow for increased use of practical activities to support learning and additional content which provides attendees with the Level 2 mandatory training competency.

The below graph outlines that there was improved staff attendance at training this quarter. In order to improve accessibility for staff of the full day Practical Application of the MCA training, the MCA Team have been delivering this training as part of ECOD's Initi8 trainee Managers Programme; following a successful pilot in July. These sessions were planned to replace the health board wide sessions available in July, August and November 2026. The team are now in discussions to look at continuing this into the next financial year.

Following a previous failed pilot to deliver a shortened version of this training to the medical workforce, the MCA team are currently working with medical education to look at how we can improve compliance and engagement with MCA related training. Details of the team's SharePoint page and its associated resources have now also been linked to the junior doctor's induction platform.

The below chart outlines attendance figures for the various training sessions offered by the MCA Team over the last quarter.



Training feedback is requested following each session of the Practical Application: Mental Capacity Assessment and DoLS in Practice face to face training and continues to demonstrate that the training is very well received by those that do attend.

Training Feedback	% Agree or strongly agree	% Neutral, disagree or strongly disagree
My learning outcomes were met	98%	2%
Training was effective and easy to understand	98%	2%
Training has increased my confidence in applying the principles of the MCA to my practice	98%	2%
The course helped with practical application of the MCA as well as theory	98%	2%
I feel confident in knowing how to access MCA support	98%	2%

Comments regarding the most meaningful thing that respondents took away from the session:

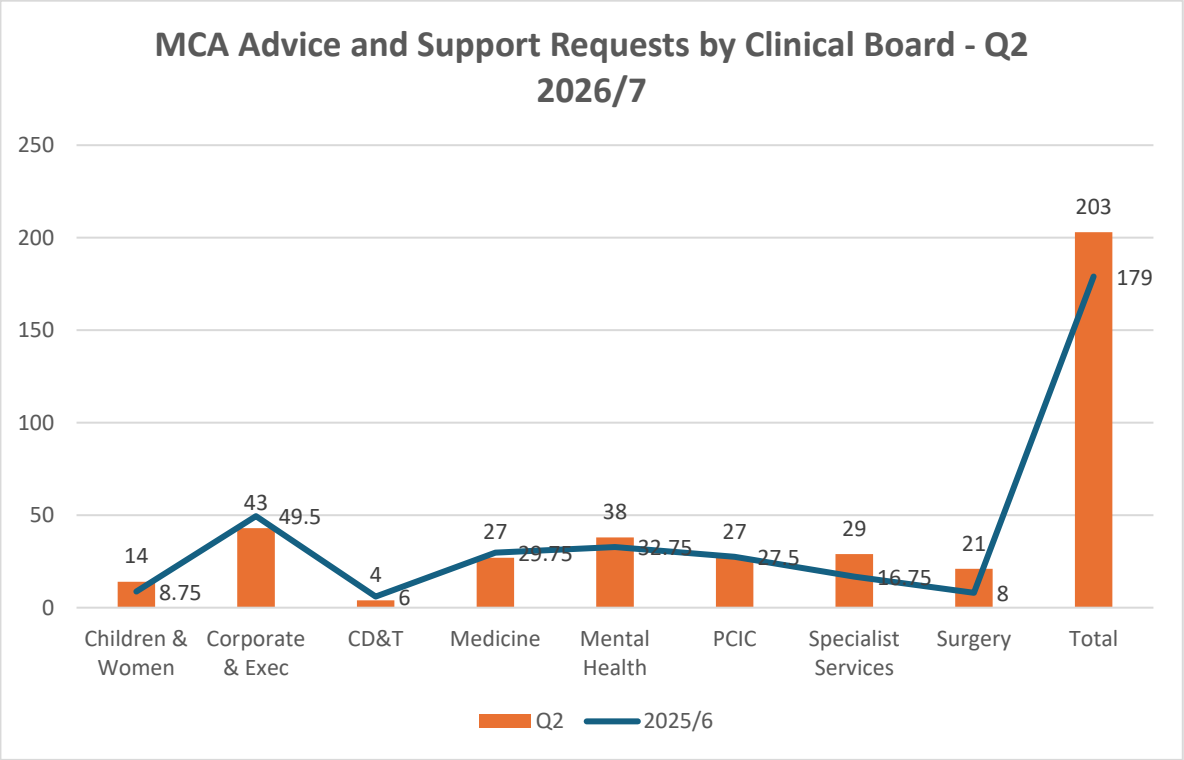


MCA Team Advice and Support

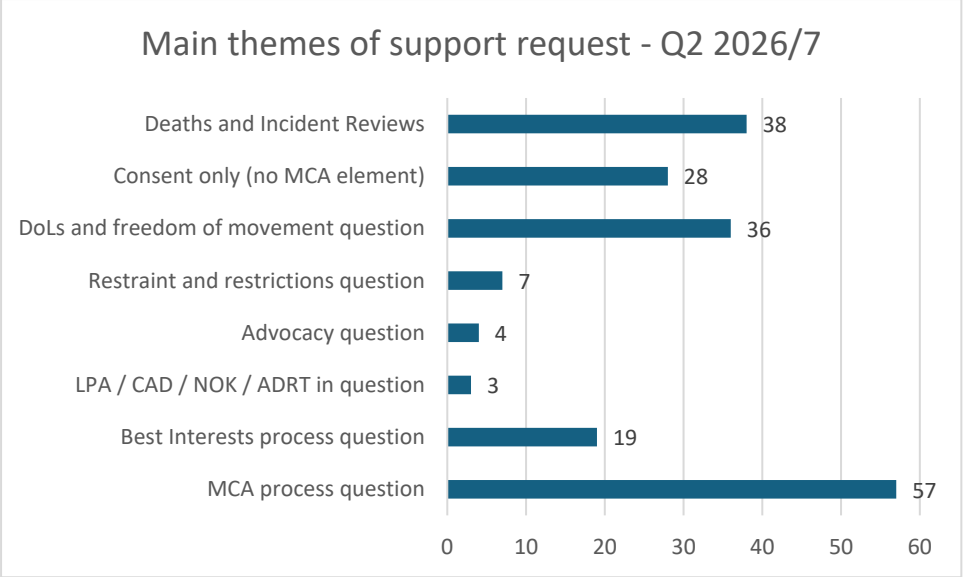
The below chart outlines the number of referrals received by each Clinical Board during Q1 with a comparison of the mean average for 2025/6 for reference.

Referral rates are generally slightly higher than the 2025/6 mean average, with the exception of Corporate & Exec and Medicine Clinical Boards. The downturn in referrals from Corporate & Exec is not currently of concern as the team continue to receive a steady stream of referrals and sit on the Mortality Screening Panel thereby screening all relevant cases and identifying MCA related learning for the organisation.

Conversely, there has been a 42% increase in referrals from Specialist Services and 62% increase in referrals from Surgery during Q2. This appears to be due to awareness raising work with these teams. The MCA Team has plans to support training across emergency medicine over the coming months so it is likely that there may be a similar upturn in referrals within medicine in Q4.



The main themes for advice and support requests are outlined below, with MCA process queries making up 28% of all referrals. Deaths and incident reviews comprise 19% and best interests (9%) and DoLS related questions (18%) are the next most notable reasons for advice and support. There is little change in the main themes of requests and this is in keeping with previous quarters.



The MCA team is currently running at reduced capacity due to maternity leave until April 2027. Whilst all queries continue to be responded to, it is acknowledged that response times will be slower and prioritised accordingly.

MCA Team Resources

Following the Supreme Court's ruling on 2nd June relating to the definition of a deprivation of liberty, all DoLS related resources will need to be reviewed and updated in light of the changes.

Following the ruling, the MCA Team have circulated communication across the health board and have developed a 7 minute briefing to educate staff whilst a training update is developed..

MCA Audit Action Plans

All Clinical Boards now have identified leads for overseeing these action plans. The main focus is on supporting staff to access available training, raising awareness of the support available and improved governance through the use of the Quality and Safety meeting framework. By having each clinical board develop their own action plan it is hoped this will better tailor the actions required to improve compliance within individual clinical boards. The MCA team are supporting implementation of action plans with involvement in audit, the delivery of service specific training and development of resources for staff though some areas are further progressed than others; with PCIC, Mental Health and Children & Women Clinical boards leading the way.

Deprivation of Liberty Safeguards Monitoring Actions:

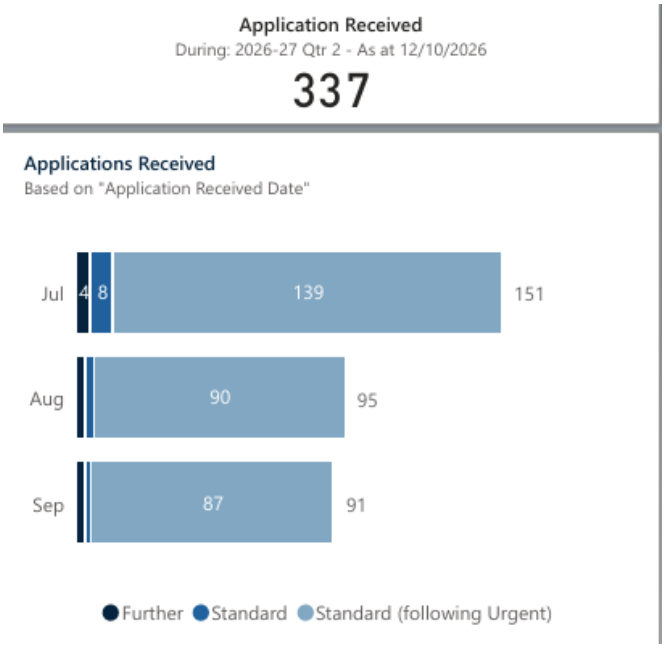
Quarterly overview from July – September 2026:

Applications Received	Assessments Carried out	Authorisations Granted	Total Waiting List	Applications Withdrawn
337	103	59	11	233

Referrals and Assessment

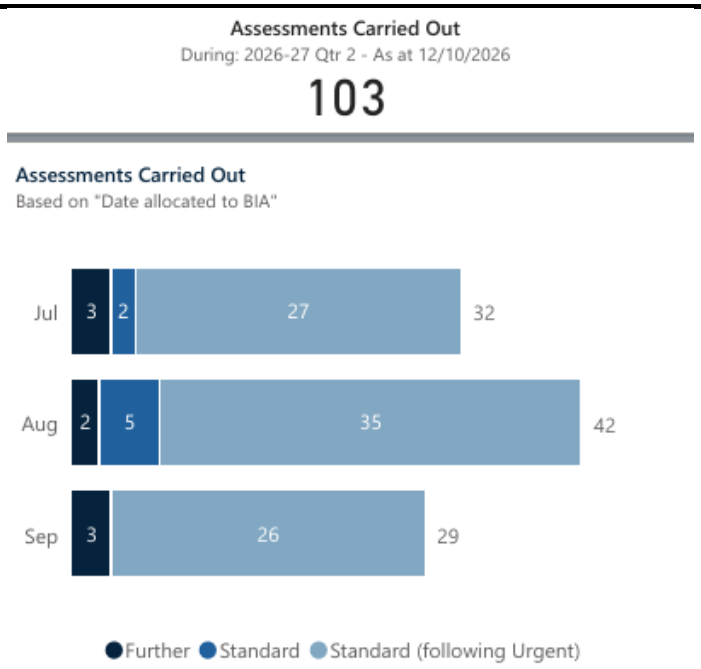
There has been a significant reduction in the number of referrals this quarter (337), compared with Q1 (522). This was following an increase in the first half of Q1 which appeared to be in response to increased awareness and understanding of when DoLS would be indicated. However, following the Supreme Court's AGNI judgement, referral rates have reduced significantly as expected; as awareness of the changes have been communicated across the UHB. As shown in the chart below, referral rates continued to fall throughout this quarter.

The MCA and DoLS Teams have made extensive efforts to communicate the changes brought about by this judgement with the provision of: 'DoLS Update Training' available weekly via Teams, email and SharePoint communications, dissemination of a 7 minute briefing detailing the changes and the development of a feedback tool for ward managers following initial review of DoLS referrals by a BIA.

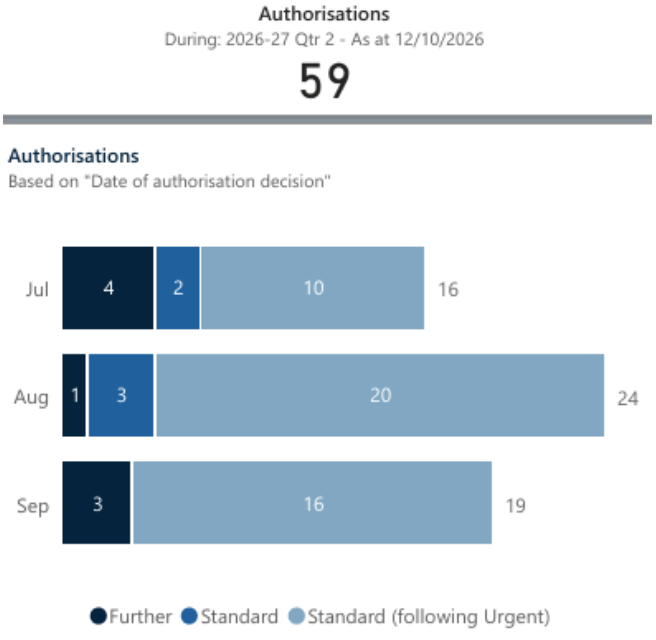


The below chart outlines the number of assessments carried out over the last quarter, by month and type. A total of 103 assessments have been undertaken this quarter, of these 44% (45) have been carried out by internal BIAs and the remaining 56% (58) by external assessors as additional assessments. Additional assessments continue to be commissioned at a rate of 5 per week to try and meet demand though this will remain under review in light of the recent changes.

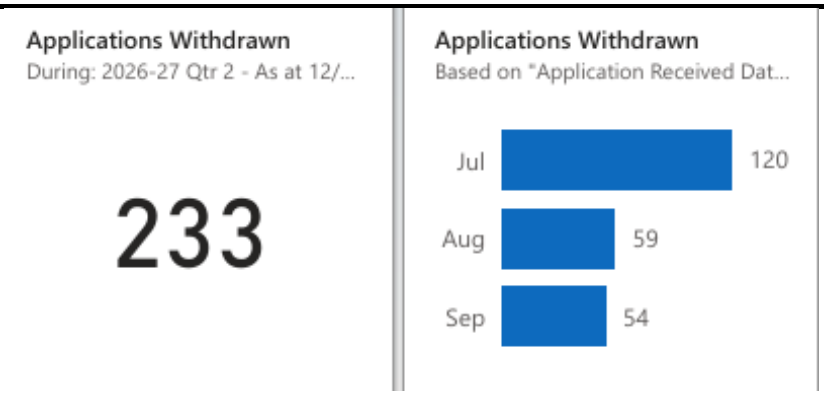
Though the number of assessments carried out has reduced from 128 undertaken in Q1, this is due to some resource being used to review referrals at the point of receipt, to ensure that assessments are only undertaken when necessary in line with the changes brought about by AGNI. Following review, ward managers are provided with feedback to outline the outcome of this initial review to provide a further learning opportunity.



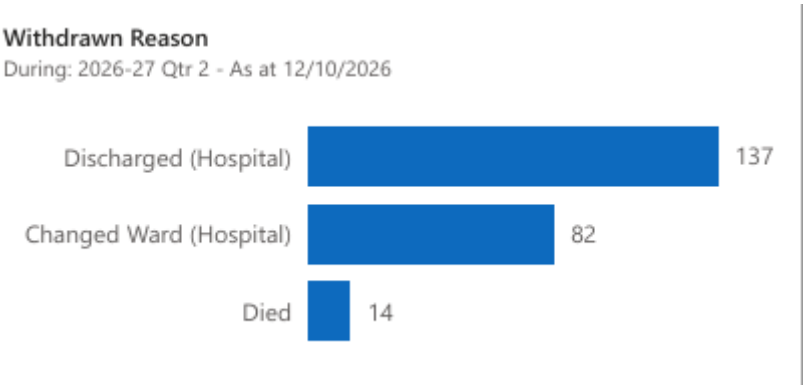
A total of 59 authorisations were granted in Q2, with an average of 19.66 authorisations per month. The number of ‘authorisations granted’ refers to the number of instances where the full authorisation process has been completed. This does not include instances where the application has been withdrawn for any reason prior to sign off by the DoLS signatory. This is in line with Welsh Government reporting processes.



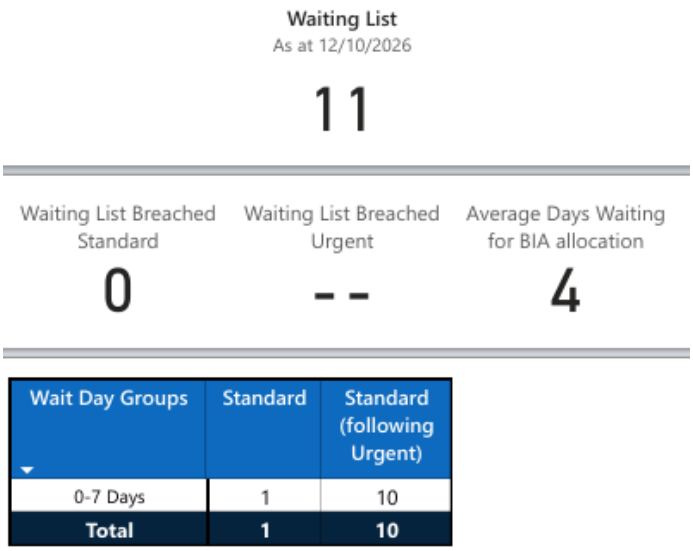
A total of 233 applications were withdrawn this quarter, compared with a mean average of 352 in 2025/6.



The reason for withdrawal of DoLS applications for this quarter are outlined below; discharge (59%), changed ward (35%) and death (6%). Due to the reporting requirements for Welsh Government the DoLS team is only able to capture these options for recording.



The waiting list has reduced significantly, to 11; down from 59 at the end of Q1.37 at the end of 2025/6, to 59 at the end of Q1 this year. Average days awaiting BIA allocation has also significantly reduced from the end of Q1 (13) to 4. These reflect the work being undertaken by the DoLS team to review referrals as they are received and to ensure that resources for assessment are allocated appropriately.



Wait Day Groups	Standard	Standard (following Urgent)
0-7 Days	1	10
Total	**1**	**10**

Impact of the AGNI Supreme Court ruling:

As outlined above, there is evidence that the Supreme Court's ruling in relation to the Attorney General for Northern Ireland's challenge (AGNI) has, and will continue to have, a significant impact on the DoLS process for the foreseeable future.

Following the judgement, the MCA Team has been working closely with the DoLS team to agree a collaborative approach to information sharing, review of cases and the development of communications. This has involved regular discussions to review referrals, promote shared understanding of the changes and allow for calibration of decision making to support more effective implementation of the changes. Following the review process referrers are provided with a detailed explanation of the review outcome and where more information if required this is clearly outlined in order to help streamline the process and minimise further delay. The aim is to support understanding of health board staff and end ensure that they are making an informed decision at the point of referral.

Appendices:

n/a

Strategic Alignment – Shaping Our Future Wellbeing:

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

Impact Assessment

Risk: Yes

There is a risk to patients, staff and the Health Board if the Mental Capacity Act or DoLS framework is not applied correctly. Key risks include unlawful decision-making or deprivation of liberty, invalid consent, delayed access to safeguards and advocacy, inconsistent practice following the AGNI judgment, and reduced organisational oversight. Controls include Clinical Board action plans, mandatory and practitioner-led training, referral review, targeted communications, audit and regular monitoring through the MCA Focus Group, Safeguarding Steering Group and Directors of Nursing.

Safety: Yes

Failure to identify and assess impaired decision-making capacity, obtain valid consent, make a lawful best-interests decision or apply the correct safeguards may expose individuals to avoidable harm, inappropriate treatment or restrictions, and delay. The reduction in training compliance and temporary reduction in MCA Team capacity may increase this risk; cases and queries are therefore prioritised, supported by action plans, training, referral review and escalation through established governance routes.

Financial: No

Not applicable. The report seeks oversight of current activity and does not request additional financial approval. Existing commissioned assessment activity and the delayed All Wales Advocacy contract will continue to be monitored through established arrangements.

Workforce: Yes

Mandatory MCA training compliance has declined across professional groups, creating a risk of variable knowledge and practice. The MCA Team is also operating at reduced capacity until April 2027, with potential for slower response times. Mitigations include prioritisation of queries, Clinical Board action plans, monthly and bimonthly compliance monitoring, expanded practical training, weekly DoLS update sessions, targeted medical engagement and accessible staff resources.

Legal: Yes

The Health Board must comply with the Mental Capacity Act 2005, its Code of Practice and the Deprivation of Liberty Safeguards, taking account of the Supreme Court AGNI judgment. Failure to apply the correct legal framework may result in unlawful treatment or restriction, challenge, regulatory

scrutiny, claims or litigation. Updated guidance, case review, training, referral feedback and governance monitoring support consistent lawful practice.

Reputational: Yes

Failure to apply the MCA and DoLS frameworks lawfully and consistently could reduce public confidence and result in adverse regulatory, legal or media attention. Transparent reporting, prompt communication of legal changes, staff training, audit, referral review and clear governance oversight mitigate this risk.

Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*

Not applicable. This is a monitoring report and does not contain a new strategic decision. Continued access to lawful decision-making safeguards and independent advocacy remains important for people who may experience disadvantage or barriers to participation.

Equality & Health: No

Not applicable. The report monitors existing statutory arrangements and does not propose a new or materially changed policy, plan, procedure or service requiring a separate Equality and Health Impact Assessment. Delivery must nevertheless remain responsive to individual communication, disability, cultural and advocacy needs, with referral patterns monitored for inequity. Any future service redesign arising from the All Wales Advocacy contract or revised legal guidance should be assessed separately.

Decarbonisation: No

Not applicable. The report does not propose a service change expected to have a material decarbonisation impact. Use of virtual update training and digital staff resources may reduce travel and printing, but this is not a primary objective of the report.

Welsh Language: Yes

Individuals must be supported to participate in capacity, best-interests and DoLS processes in their preferred language. Welsh-language need should be actively identified and recorded, with bilingual information, interpreters or Welsh-speaking support made available where required. Training and staff resources should meet Welsh Language Standards, and referral data should continue to be monitored to ensure language need is accurately captured and addressed.