Public Quality Committee
2nd June 2026
09:00 via MS Teams
Public Agenda

1. 09:00	**Standing Items**	**Assurance Approval Noting/Info**	**Lead**
1.1	Welcome, Introductions & Apologies		Ceri Phillips
1.2	Declarations of Interest		Ceri Phillips
1.3	Minutes of the Quality Committee Meeting held on 14.04.2026		Ceri Phillips
1.4	Action Log		Ceri Phillips
1.5	Chair's Actions taken since last meeting - *none*		Ceri Phillips
2. 09:10	**Quality Performance Reporting**		
2.1 *15 mins*	Quality Performance Report	Assurance	Alex Scott / Adam Wright
3. 09:25	**Strategic Portfolio: Providing Outstanding Quality**		
3.1 *5 mins*	Board Assurance Framework *The Board Assurance Framework can be found in the 'Supporting Documents' folder.*	Assurance	Matt Phillips
3.2 **09:30** *5 mins*	**Shaping our Population Health and Place-Based Partnerships:** • *3.2.1 - Update for Women's Health Hubs*	Assurance	Claire Beynon Michael Allum
3.3 **09:35** *10 mins*	**Shaping our Quality, Value & Sustainability** • *3.3.1 - Quality Management System (QMS) Improvement Plan*	Approval	Natasha Goswell
3.4 **09:45** *10 mins* *10 mins* *10 mins* *10 mins*	**Shaping our Future Clinical Services** • *3.4.1 - Theatres Together (the Improvement Plan can be found in the 'Supporting Documents' folder.* • *3.4.2 - Pathway to Safer Beginnings (Wales): Gap Analysis and Proposed Three-Year Improvement Programme* • *3.4.3 - JACIE Inspection Update* • *3.4.4 - HIW Short Stay Surgical Unit (SSSU) (the Improvement Plan can be found in the 'Supporting Documents' folder)*	Assurance Assurance Assurance Assurance	Paul Bostock Abi Holmes Jess Castle Alex Scott
4. 10:25	**Items for Oversight / Scrutiny**		

4.1 **10:25** *10 mins* *10 mins*	Clinical Audit highlight report • *4.1.1 - Additional Learning Needs (ALN) Internal Audit report update* • *4.1.2 - Clinical Audit Forward Plan 2026/27*	Assurance Noting	Natalie Vanderlinden Aled Roberts / Alex Scott
4.2 **10:45** *30 mins*	Clinical Board Quality highlight reports: • *4.2.1 - Medicine CB* • *4.2.2 - Surgery CB* • *4.2.3 - Children & Women* • *4.2.4 - PCIC CB* • *4.2.5 - CD&T CB* • *4.2.6 - Specialist Services CB* • *4.2.7 - Mental Health CB* *The Clinical Board QSE Minutes can be found in the '**Supporting Documents**' folder.*	Assurance	Jason Roberts Paul Bostock Emma Cooke Claire Beynon
4.3 **11:15** *10 mins*	Annual Reports: • 4.3.1 - Claims Annual Report 2025/26 • 4.3.2 - Patient Experience Annual Report 2025/26 *The Annual Reports can be found in the '**Supporting Documents**' folder.*	Assurance	Angela Hughes
5. 11:25	**Policies for Approval**		
	No policies for approval.		
6. 11:25	**Items for Noting / Information**		
6.1 *5 mins*	Safeguarding Steering Group (SSG) Minutes – 11.03.2026 *The SSG Minutes can be found in the '**Supporting Documents**' folder.*	Assurance	Jason Roberts
7. 11:30	**Are there any items from the meeting that require escalation to Board?**		
8.	**Any Other Business**		
9.	**Review of the Meeting**		
10.	**Date & Time of Next Meeting:** *30th June 2026 via MS Teams*		

Draft Minutes of the Public Quality Committee

Held on 14th April 2026 via MS Teams

To view the meeting: https://youtu.be/UKNth5j7Wns

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Judi Rhys	JRH	Independent Member – Third Sector
Rachna Upadhya	RU	Independent Member - General
In Attendance		
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Natasha Goswell	NG	Deputy Executive Nurse Director
Angela Hughes	AH	Assistant Director of Patient Experience
Matt Phillips	MP	Director of Corporate Governance
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
David Fluck	DF	Executive Medical Director
Additional Attendees		
Lauranne Cullen	LC	Regional Director for Llais
Jessica Castle	JC	Director of Operations – Specialist Services Clinical Board
Rachel Dix	RD	Interim Deputy Director of Mental Health Nursing - Mental Health Clinical Board
Rim Al-Samsam	RAS	Clinical Board Director - Mental Health
Dalia Alhusseini	DA	Equity and Health Improvement Officer
Elaine Lewis	EL	General Manager - Pharmacy
Rhodri Clyburn	RC	Pharmacist
Em Wilkinson-Brice	EWB	Independent Advisor – NHS Performance & Improvement
Pamela Johnston	PJ	Independent Advisor – NHS Performance & Improvement
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Suzanne Rankin	SR	Chief Executive Officer
Stephen Riley	SR	Independent Member – University
Kirsty Williams	KW	UHB Chair

		ACTION
QC 2026/04/1.1	**Welcomes, Introductions & Apologies** Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh. Apologies for absence were noted.	
QC 2026/04/1.2	**Declarations of Interest**	

	No declarations of interest were raised.	
QC 2026/04/1.3	**Minutes of the Committee meeting held on 03.03.2026** The minutes of the Committee meeting held on 03.03.2026 were received. **The Committee resolved that:** a) The minutes of the meeting held on 03.03.2026 were approved as a true and accurate record of the meeting.	
QC 2026/04/1.4	**Action Log following the Meeting held on 03.03.2026** The Action Log following the Meeting held on 03.03.2026 was received and discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 03.03.2026 was noted.	
QC 2026/04/1.5	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QC 2026/04/2.1	**EPMA Programme Trajectory and Data** Elaine Lewis (EL), the General Manager – Pharmacy, and Rhodri Clyburn (RC), Pharmacist, provided an update on the progress with the Electronic Prescribing and Medicines Administration (ePMA) programme. They summarised the following: • The pilot commenced in July 2025 and had since been rolled out across most inpatient areas, supported by clinical leads and floor-walking teams. • ePMA was now live across the majority of CAVUHB sites, with remaining inpatient areas scheduled to go live by the end of June 2026, including Intensive Treatment Unit (ITU), paediatrics, maternity, Marie Curie hospice, and Neonatal Intensive Care Unit (NICU). They hoped to work on outpatients towards the end of the calendar year. • Key achievements included first-in-Wales implementation in the Emergency Unit (EU), national first use of NerveCentre ePMA in mental health, and significant improvements in discharge advice letter completion (with incomplete letters previously at around 20% to 3%) • The system had been widely adopted, with over 5000 users, more than 2 million medicine administrations completed, and improvements in medicines safety, patient identification, and data visibility. • Future work included completion of inpatient rollout, system optimisation, use of ePMA for home care, and scoping a separate ePMA programme for outpatients, including potential integration with the Electronic Prescription Service (EPS). Paul Bostock (PB), the Chief Operating Officer, asked when evidence would be available to demonstrate the impact of ePMA on medicines safety, including reductions in medication errors and waste, given the scale of system usage to date. RC advised that safety benefits should become clearer within the current calendar year, drawing on incident data and key measures such as VTE compliance and missed doses. The next phase would focus on benefits realisation and system optimisation through refinement of the system, training and data analysis to evidence safety impact.	

PB asked whether given the volume of activity to date, there was early evidence of improvement.

RC responded that it was still too early to draw firm conclusions on safety impact, though early feedback from the first Clinical Board to go live suggested a reduction in reported drug errors, which was viewed as a positive early indicator.

CP suggested that data demonstrating the impact of ePMA on patient safety and quality be made available – ACTION.

EL responded that they had agreed to go to the Senior Leadership Team (SLT) within the next 4-5 months with this data, so can share with the Quality Committee also.

Jason Roberts (JR), the Executive Nurse Director, asked whether the implementation of ePMA had introduced any new or different patient safety risks.

RC provided the following response:

- The risks associated with ePMA largely related to human interaction with digital systems rather than the technology itself
- Identified risks included drop-down selection errors, alert fatigue from clinical decision support warnings, and users bypassing safety features such as alerts and barcode scanning
- Some incidents had arisen where alerts were overridden or scanning processes were not followed, reducing the effectiveness of built-in safety controls
- The importance of understanding user behaviour was emphasised, alongside the need for mitigations through system design, training, and awareness to minimise avoidable risks and improve safe use of the system.

EL added that alert overrides and alert fatigue were well-recognised risks within ePMA, with national evidence showing alerts can be frequently overwritten if not well designed.

EL acknowledged that an increase in reported drug incidents was anticipated due to improved visibility compared to paper systems and historic under-reporting.

RC explained that the UHB would join the national ePRaSE programme from September, providing six-monthly assessments of local ePMA configuration against clinical scenarios to support continuous system optimisation and improvement.

Judi Rhys (JR-IM), the Independent Member – Third Sector, asked about confidence levels in delivering the remaining ePMA activity to the agreed timeline, and asked about opportunities to share learning and good practice from the programme.

EL responded that the programme was ambitious but was on track, with confidence expressed in completing the inpatient rollout, whilst NICU presented specific clinical challenges still being addressed. Outpatient implementation would proceed regardless of EPS readiness. EL added that learning from the programme was being actively shared across the organisation, including with Shaping Change and the digital foundations teams.

Alex Scott (AS), the Assistant Director of Quality and Patient Safety, explained that the Shaping our Future Quality Excellence (SOFQE) Programme included a medicines safety workstream focused on reporting culture and quality indicators, with robust audit data available in some areas, which could be used to assess quality and wider patient safety impact despite limitations in baseline data.

The Committee resolved that:

	A) The update provided as requested by the previous Quality Committee was noted.	
QC 2026/04/2.2	**Prevention of Future Death (PFD) Response** Angela Hughes (AH), the Assistant Director of Patient Experience, presented an overview of a Regulation 28 report to PFDs issued by the coroner following a missed critically abnormal vitamin B12 result, which was found to have contributed to a patient death. AH provided the following summary: • Key risks identified included reliance on a single consultant within the Perioperative Care of Older People Undergoing Surgery (POPS) service without formal cross-cover, and the potential of abnormal results being missed. • The UHB submitted a timely response and implemented immediate mitigations, including interim cross-cover arrangements, revised laboratory procedures with monthly audit assurance showing full compliance, and strengthened oversight via the Welsh Clinical Portal. • Additional actions included improvements to how results were displayed to clinicians by Digital Health and Care Wales (DHCW), increased staffing within the POPS team, and enhanced consultant review processes • Residual risk remained due to growing service demand, and the Clinical Board was considering longer-term sustainable service models to maintain patient safety and system resilience. Lauranne Cullen (LC), the Regional Director for Llais, asked whether there was a defined deadline for completion of the workforce expansion plan, and what contingency arrangements were in place should recruitment be unsuccessful. AH confirmed that team cover was in place, with recruitment to the specialist nurse post underway. AH would provide confirmation and feedback to LC outside of the meeting. JR emphasised that whilst this case related to vitamin B12, the learning must be applied more widely across the organisation to strengthen the management and follow-up of blood results and medicines safety processes overall. AH noted that emerging work by DHCW to present results in a single, clearly prioritised view, including time-critical actions, should significantly improve the management of abnormal results, with learning applicable beyond B12 to other medicines requiring timely follow up. Claire Beynon (CB), the Executive Director of Public Health, asked how frequently urgent action blood results occurred and whether laboratory staffing was sufficient to ensure timely action and escalation. AH responded that although such incidents were rare due to multiple existing fail-safes, this case highlighted how failures at several points could align, particularly around discharge processes and result follow-up. The true frequency was difficult to quantify due to reliance on reporting and reinforced the need for improved systems. Aled Roberts (AR), the Associate Medical Director Patient Safety and Clinical Effectiveness, explained that clear protocols were in place for “panic” results requiring action within 15 minutes, supported by a developing communication plan covering both hospital and community settings. The work being undertaken by DHCW was parallel to improve visibility and follow-up of non-urgent but abnormal results through digital enhancements. **The Committee resolved that:**	

	A) The Regulation 28 Report and Health Board response was noted.	
QC 2026/04/2.3	**Royal College of Psychiatry Review Update from the Mental Health Clinical Board (MHCB)** Rachel Dix (RD), the Interim Deputy Director of Mental Health Nursing - Mental Health Clinical Board, presented an update to the Committee of progress against the RCP's report following a cluster of inpatient suicides (2021-2022), including delivery of actions aligned to the 36 Degrees transformation programme. The following was summarised: • Significant progress had been made across key areas including risk assessment (transition to WARRN), care and treatment planning, therapeutic engagement and observation, continuity of care, discharge processes, Mental Health Act (MHA) practice, family engagement, leadership and supervision, and serious incident review standards. • Risk Assessments – risk assessments had transitioned from Form 4 to WARRN, now embedded but with ongoing challenges. Further work was needed to strengthen risk management and consistency, aligned to an All-Wales approach. Plans were in place to introduce WARRN as a Tier 2 audit using AMAT for better data use and oversight. A risk management policy had been reviewed and was currently out for consultation. • Care and Treatment Planning – co-produced care and treatment planning training was in place and linked to discharge preparation. An All-Wales training approach was being developed with ESR. A new care and treatment planning procedure to support the continuity of care was out for consultation. • Therapeutic Engagement and Observation – a co-produced therapeutic observation approach had been implemented, focusing on relational care and supported by training. Weekly 1:1 compliance was monitored (target was 100%), with some gaps being addressed. A SafeCare red flag system highlighted risks on the ability to undertake 1:1 observations in real time. • Continuity of Care – they had embedded the transfer checklist, with a policy under review. The transition and recovery ward had reduced out-of-speciality placements. Discharge letters had improved (closer to the 24-hr target) following ePMA, with work ongoing to enhance the quality. 72-hr follow-up for all discharges was being piloted in line with All Wales standards. • Diagnosis, Treatment, and MHA – the use of language was being addressed through training, ongoing audit, and external support from the MHA office. Key policies relating to Section 5(2) and 5(4) had been reviewed to ensure clarity and consistency. A new open and locked door policy was out for consultation to improve transparency for staff and patients. • Family Engagement – co-produced family engagement guidance had been developed to support information sharing and handling sensitive conversations. A two-year family engagement project was underway (mid-point) which aimed to strengthen family and carer involvement across the MHCB. • Leadership and Supervision – progress was being made on nursing establishments and MDT review, linked to the 36 Degrees transformation programme. Recruitment of dedicated inpatient social workers was expected to improve care. Clinical supervision had been strengthened with a new procedure, but monitoring was limited due to the lack of ESR recording. Further work was needed to define the optimal MDT model and improve supervision oversight. • SIRAN Standards – SIRAN accreditation had been maintained, which demonstrated compliance with the Royal College standards for incident reviews and family and staff engagement. The service had been recognised as a good practice exemplar, particularly for family involvement, terms of reference, and the use of AMAT for improvement tracking.	

	- Work was progressing on NHS Wales discharge standards, supported by co-produced discharge and admission materials and an All-Wales ligature risk assessment. Some areas remained outstanding and linked to the 36 Degrees programme. These would be strengthened through Tier 2 audits to improve monitoring and alignment with All-Wales requirements. PB asked for clearer visibility of any remaining gaps following the RCP report, including proposed timescales for addressing them, and suggested that the 36 Degrees programme could provide independent validation of progress to give additional assurance. JR agreed that independent validation through the 36 Degrees programme could provide additional assurance. JR asked whether the implementation of the WARRN risk assessment introduced new risks and how staff confidence and cultural transition were being supported. RD responded with the below: - There was an ongoing effort to shift the culture around WARRN away from a tick-box approach towards a more psychologically informed, formulation-based assessment of risk, led with support from psychology colleagues. - Whilst WARRN served a purpose, it was not consistently embedded in clinical practice and there was all-Wales resistance to it as a tool, which prompted discussions about alternatives. - Suicide awareness and mitigation training, alongside safety planning, had been more effective in changing practice, with targeted and team-based training, additional guidance, and a new risk management policy supporting this work. - This formed a key and evolving workstream within the safety pillar's risk project plan. JR provided assurance to the Committee that this would be scrutinised through Executive Reviews. AS explained that a paper on Clinical Board's audit forward plans would be brought to the following Committee to provide ongoing assurance and feeding into the Clinical Board and UHB risk registers where risks were identified. **The Committee resolved that:** A) The update provided to the Committee was noted.	
QC 2026/04/2.4	**Equity, Equality, Experience and Patient Safety Action Plan** CB presented the six-monthly update on the Equity, Equality, Experience and Patient Safety Action Plan, and highlighted the below: - Under the Equality Act 2010, the UHB had a duty to identify and address inequities in access, experience and outcomes, which aligned with the vision for 2035 to reduce unfair health differences. - To support this, a 3i Framework and implementation toolkit was developed in 2023, with progress against the action plan reported to the Quality Committee every six months. AH explained that work was underway on accessible standards, with gaps in adherence which contributed to communication-related inequities. A new translation and accessible standards policy was being drafted, and there was a clear need to link with this work	

	with related equality initiatives. AH suggested linking with CB's team outside of the meeting. JR-IM asked about the reported increase in the ethnic minority workforce and sought clarity on whether this reflected local recruitment or international recruitment. She also queried why this data was not readily available and whether the source of recruitment mattered. CB responded that if the information was not readily available, it was likely because ESR data did not distinguish between local and international recruitment. In response to whether it mattered, CB responded that she did not think so. **For a further update to come back to the Committee in six months – ACTION.** **The Committee resolved that:** A) The actions underway in the action plan to address health inequalities in Cardiff and the Vale of Glamorgan were supported and advocated; B) The six-month progress that had been made against the actions, including the challenges around health inequality data availability, were acknowledged; C) To receive further updates in another six months was agreed.	
QC 2026/04/2.5	**JACIE Inspection Report Update** Jessica Castle (JC), the Director of Operations – Specialist Services Clinical Board, provided the Committee with the following update: • The JACIE inspection was undertaken in September 2025, with reaccreditation currently deferred pending submission of a credible corrective action plan by 8th July 2026. • Whilst the majority of standards were compliant, areas of non-compliance and partial compliance were being tracked through a dedicated Task & Finish Group (T&FG) which reported regularly through governance structures. • Adult Premises (CAVUHB) - good progress was being made on the Haematology Day Centre, although groundworks issues had delayed completion by a few months. A revised timeline would be included in the response to JACIE. The main risk remained the wider capital scheme for the inpatient ward, which was still in the planning stages. The UHB hoped to have a completed internal business case, sought a support letter, and developed a high-level project plan by the JACIE deadline. • Paediatrics (Clinical) - concerns focussed on low patient volumes in the paediatric programme, below expected standards. Mitigation included closer working between adult and paediatric teams to maintain competencies. A robust organisational decision was required on the future of the autologous transplant programme. An options paper was being developed which would go through the Clinical Board and the Strategic Leadership Team (SLT) in May. The outcome would inform the formal response to the JACIE. • Swansea Bay UHB (SBUHB) Personnel – JACIE had identified issues at SBUHB including medical staffing gaps, over-reliance on a single specialist nurse, and gaps in prehabilitation and nurse-led services compared to CAVUHB. SBUHB had produced a paper outlining the requirements to achieve parity with CAVUHB, which would be presented to SLT. • Stem Cell Unit Personnel – the unit was identified as a key concern due to staffing gaps, insufficient on-call cover, and weaknesses in risk controls following a recent adverse event. A paper was being developed for SLT to agree next steps. Any proposals requiring additional resources would need approval through JCC as the service commissioner.	

	• <u>Next Steps</u> – a T&FG oversaw delivery of action and provided regular assurance to SLT, the JCC had been briefed and WG discussions on capital plans were ongoing, the paediatrics options appraisal and the SBUHB workforce business case had been completed and were progressing through governance, and the Quality Team were addressing the remaining areas of non-compliance. JR-IM asked how ongoing discussions with WG, including the impact of the election period, was affecting progress and contributing to delays. JC responded that work on the business justification case (BJC) was still ongoing, so the election period was not currently causing delay. The main challenge was uncertainty linked to potential changes in government, meaning approval could not be confirmed. The focus remained on finalising the BJC, progressing internal govern ance, and preparing supporting documentation. Final ministerial approval was outside of local control. **For an update to come back to the following Quality Committee – ACTION.** **The Committee resolved that:** A) The progress and risks were noted.	
QC 2026/04/2.6	**Structured Assessment, Internal Audit, Targeted Intervention De-escalation Criteria Overarching Quality Improvement Plan** Natasha Goswell (NG), the Deputy Executive Nurse Director, presented the overarching Quality Improvement Plan for assurance, and highlighted the following: • The improvement plan consolidated actions from the internal audit on Quality and Safety Governance, the Structured Assessment 2025, and targeted intervention de-escalation criteria • The plan provided a single line of site on 22 requirements, clearly setting out actions, owners, evidence and reporting routes, and aligned to the organisational strategy. • Delivery would be overseen through weekly executive quality meetings using AMAT, with formal reporting to the Quality Committee monthly initially, moving to quarterly, and included assessment of risks and safety impacts should improvements not be delivered. JR noted that the plan brought together the integrated Quality Improvement Framework into a single, coherent approach, supporting future development of the Quality Committee. It would also be embedded within the Quality Management System (QMS) to make quality improvement everybody's business. CB emphasised the need to ensure equity was included as one of the quality elements. **The Committee resolved that:** A) The contents of the overarching Quality Improvement Plan were noted for awareness; B) The actions being taken to address the areas identified for improvement and the governance arrangements for oversight of the reporting and monitoring of the improvement plan were noted for assurance.	
	Items for Approval / Ratification	
QC 2026/04/3.1	**Policies** *No policies for approval.*	

QC 2026/04/3.2	**Quality Committee Annual Report 2025/26** Matt Phillips (MP), the Director of Corporate Governance, explained to the Committee that the Annual Report formed part of the annual end-of-year reporting cycle. It provided a high-level summary of the year, complementing existing minutes, reports, and Chairs updates. **The Committee resolved that:** A) The Quality Committee Annual Report was endorsed for approval at Board.	
	Items for Noting & Information	
QC 2026/04/4.1	**Minutes from the Clinical Board QSE Sub-Committees** **The Committee resolved that:** A) The Clinical Board QSE Sub-Committee minutes were noted.	
QC 2026/04/4.2	**Safeguarding Steering Group (SSG) Minutes** JR assured the Committee that the absence of minutes reflected timing only. The Group had met in March, and their papers would be brought to the next Committee following ratification.	
QC 2026/04/4.3	**IP&C Group Minutes** JR assured the Committee that the absence of minutes reflected timing only. The Group had met in March, and their papers would be brought to the next Committee following ratification.	
QC 2026/04/4.4	**Public Health Wales Sexual Health Incident** CB provided the following summary to the Committee: • This incident involved Public Health Wales's (PHW) sexual health test-and-post service, which was used by some CAVUHB patients. • Whilst the service remained safe and operational, issues were identified relating to ineffective safeguarding and data handling processes. • PHW had taken appropriate action, issued an apology, and published supporting information and FAQs online. • PHW had advised that they all affected individuals had been contacted, corrective actions were in place, and follow-up support, including a helpline, remained available. JR provided assurance to the Committee that the CAVUHB Safeguarding Team had reviewed the patient cohort and confirmed there were no safeguarding concerns from a UHB perspective. **The Committee resolved that:** A) The contents of the report were noted; B) The actions undertaken by CAVUHB in response to the incident were noted.	
	Agenda for Private Quality Committee Meeting	
QC 2026/04/5.1	*i) Minutes and Action Logs from the Private QSE Committee on 03.03.2026* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*	

	iii) Eating Disorder Service Review Update *iv) Health Inspectorate Wales - SSSU* *v) Inquest Outcome, Organisational Learning and Assurance* *vi) Public Health Wales Hepatitis C Incident*	
	Any Other Business	
QC 2026/04/6.1		
	Date & Time of Next Meeting:	
QC 2026/03/7.1	2nd June 2026 at 2pm via MS Teams	

Title	Minute Reference	Agreed Action	Executive Lead	Action Lead	Date Assigned	Date for Review	Action Status	Action Update
ePMA Programme Trajectory and Data	QC 2026/04/2.1	For data demonstrating the impact of ePMA on patient safety and quality be circulated to the Committee.	Jason Roberts	Rhodri Clyburn, Elaine Lewis	14/04/2026	14/09/2026	IN PROGRESS	Once data has been circulated to Committee Members, this action can be marked as Complete.
Equity, Equality, Experience and Patient Safety Action Plan	QC 2026/04/2.4	For an update to come back to the Committee in six months.	Claire Beynon	Claire Beynon	14/04/2026	06/10/2026	ON FORWARD PLAN	On the Forward Plan for 6th October 2026 Quality Committee.
JACIE Inspection Report Update	QC 2026/04/2.5	For an update to come back to the following Committee.	David Fluck	Jessica Castle	14/04/2026	02/06/2026	ON FORWARD PLAN	Item on 2nd June 2026 Quality Committee meeting agenda.

Report Title: *(needs to match agenda)*	Board Assurance Framework - Quality		Agenda Item No:	2.1
Meeting:	Quality Committee	Public: X / Private:	Meeting Date:	2 Jun 26
Lead Executive Title:	Director of Corporate Governance			
Report Author/s Title:	Director of Corporate Governance			

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)*

While the BAF is familiar at Board as an assurance tool, it is not yet established at Committee level for Quality and so the purpose of this report is to introduce a discussion within the new Committee format for how this report is to be used going forwards.

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

Board/Committee Response Required

Assurance	X	Approval		Information/Noting	

Recommendations

The Committee is requested to:

- note the contents of the 2 Quality Committee aligned strategic risks – Quality and Health Equity;
- **discuss** how the committee wishes to receive and use the BAF within the architecture of the new Committee format.

Governance Route

Where *it's been:*	Board
When *it went:*	28 May 26
What *decision was made:*	Discussed and noted

Main Report

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

The 2 delivery focused risk themes are:

Quality
Health Equity

And there are 4 key enabling risk themes:

People

Digital
Infrastructure
Sustainability

This is how it aligns:

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	

The BAF should speak to the risks to delivering the strategy and is discussed at every Board meeting. All 6 risk themes apply to all 4 strategic objectives (and the 6 strategic portfolios) but to provide proportionate scrutiny each theme is aligned to a Committee. The 2, delivery focused, risk themes are aligned with the Quality Committee as per above.

The Committee is requested to consider how it wishes to make use of the BAF within the Quality Committee.

Appendices

1. BAF extract for Quality and Health Equity risk themes.

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: Please select
N
Safety: Please select
N
Financial: Please select
N
Workforce: Please select
N
Legal: Please select
N
Reputational: Please select
N
Socio Economic: Please select - *https://www.gov.wales/socio-economic-duty-guidance*

N
Equality & Health: Please select
N
Decarbonisation: Please select
N
Welsh Language: Please select
N

Board Assurance Framework

Updated 28 May 26

Introduction

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

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

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

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

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

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

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

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

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

Strategic Framework

<table>
<tr><th colspan="7">Strategic Framework</th></tr>
<tr><td>Strategy</td><td>Putting People First</td><td colspan="3">Providing Outstanding Quality</td><td>Delivering in the Right Places</td><td>Acting for the Future</td></tr>
<tr><td>Strategic Portfolio</td><td>Shaping Our Future People & Culture</td><td>Shaping Our Future Population Health & Place Based Partnerships</td><td>Shaping Our Future Quality, Value & Sustainability</td><td>Shaping Our Future Clinical Services</td><td>Shaping Our Future Infrastructure</td><td>Shaping Our Future Generations</td></tr>
<tr><td rowspan="2">Strategic Risk Theme</td><td rowspan="2">People</td><td colspan="3">Quality</td><td>Digital</td><td rowspan="2">Sustainability</td></tr>
<tr><td colspan="3">Health Equity</td><td>Infrastructure</td></tr>
<tr><td rowspan="3">Committees</td><td rowspan="2">People and Culture Committee</td><td colspan="3">Quality Committee</td><td rowspan="2">Digital and Infrastructure Committee</td><td rowspan="2">Finance and Performance Committee</td></tr>
<tr><td colspan="3">Mental Health Committee</td></tr>
<tr><td colspan="6">Audit & Assurance</td></tr>
</table>

Strategic Objectives

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

Strategic Risks – Quality

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

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

Strategic Risks – Quality

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

Strategic Risks – Quality

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

Strategic Risks – Quality

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

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

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

Strategic Risks – Quality

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

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

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

Strategic Risks – Quality

<table>
<tr><td colspan="3">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.</td><td colspan="2"></td></tr>
<tr><td colspan="3">Gaps in Controls</td><td colspan="2">Gaps in Assurances</td></tr>
<tr><td colspan="3">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</td><td colspan="2">The control gaps identified mean that assurance at Committee and Board level is undermined and so the Committee work is being reviewed and redeveloped.</td></tr>
<tr><td colspan="5">Risk Post-Controls and Mitigation</td></tr>
<tr><td>Impact: 5</td><td>Likelihood: 3</td><td colspan="2">Net Risk: 15</td><td></td></tr>
</table>

Strategic Risks – Quality

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

Strategic Risks – Quality

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

Strategic Risks – Quality

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

Strategic Risks – Health Equity

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

Risk

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

Cause

Risk: a lack of investment in prevention

- Our organisation aims to shift spending from reactive hospital care towards prevention and proactive care in community settings. However, secondary care continues to receive an increasing share of NHS funding, leaving prevention under-resourced. Addressing this imbalance is essential for our long-term sustainability.
- There is currently a lack of capacity to deliver evidence-based interventions at scale to tackle smoking, obesity, vaccination, alcohol, substance use etc. that drive the huge disparities in health outcomes we see across Cardiff and the Vale of Glamorgan.
- There is currently a lack of capacity to undertake more substantial work on the wider determinants of health with partners, such as improving housing and educational attainment, employment etc.
- There is currently a lack of investment in prevention: the Faculty of Public Health recommends 15 public health consultants for a population of 500,000, we employ 5.5 WTE.

Risk: a deterioration in the wider determinants of health

- Health inequalities are well documented across the UK and arise in three main ways:
  - structural issues e.g. income, employment, education and housing
  - unhealthy behaviours due to the environment, social norms and income levels
  - inequitable access to, or experience of, services, which can be a result of discrimination due to inaccessible services, public information or

Impact

Potential impacts associated with this risk include:

- Greater illness and poorer access to care (the inverse care law) will contribute to worse health outcomes. This impacts directly on the gap in life expectancy between the most and least deprived, resulting in a worsening of the gap in life expectancy and healthy life expectancy between different members of our population.

- Health inequalities are already estimated to cost £3-4 billion annually in Wales through higher welfare payments, productivity losses, lost taxes, and additional illness. The total annual cost associated with inequality in hospital service utilisation to the NHS in Wales is estimated to be £322 million, equivalent to 8.7% of the total hospital service expenses, driven largely by higher service use among people living in the more deprived areas compared to those living in the least deprived (PowerPoint Presentation (nhs.wales)). A lack of investment in prevention will cause an increase in future health service costs associated with health inequities.

Potential impacts associated with mitigation of this risk include:

- Taking action on health inequalities can reduce premature mortality, reduce social disparities, and reduce the absolute time in ill health for people in our communities. For example, using an NHS service such as 'Help Me Quit' can increase a person's chance of successfully quitting. 'Help Me Quit' clinic provision is aligned with areas where smoking prevalence and deprivation are highest to help reduce barriers to service access.

Strategic Risks – Health Equity

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

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

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

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

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

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

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

Strategic Risks – Health Equity

• 'Shaping our Inclusive Culture 2024-2028' is closely aligned with the UHB Shaping our Future Well-being. • The refreshed UHB Strategy 'Shaping our Future Well-being' shines a light on the issue of equity at the strategic level. • The Cardiff and Vale Long-term Public Health Plan 2024 – 2035 sets out how the UHB intends to achieve its ambitions of increasing life expectancy, reducing inequity and shifting more focus to prevention. • 'Shaping our Inclusive Culture 2024-2028' is closely aligned with the UHB Shaping our Future Well-being. • Through our PSB and RPB plans we already prioritise areas of work to tackle inequalities and the refreshed needs assessments for both PSBs and RPB have further identified collective actions. • The future UHB organisational direction agreed at the recent rapid planning event supports the 'shift upstream' by committing to develop an Integrated Community Health System, underpinned by care pathways that begin with prevention; prevention is a 'brilliant basic'. An 'Equity, Equality, Experience and Patient Safety' action plan was approved by Board in May 2024, covering 24 initial actions across the Clinical Boards that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. Progress on actions is reported to Quality Committee on a 6-monthly basis (most recent update provided in February 2026). Ongoing review is undertaken to identify outstanding actions and create future actions using the framework. • The Health Board is continuing to implement and periodically review its strategy to tackle the lower and unequal uptake of vaccination in our most deprived communities, using an intelligence driven approach and involving targeted, behaviourally informed communications and engagement. • The establishment of a Strategic Diabetes Programme Board is a key element to reducing health inequalities and has an aim to identify those with undiagnosed diabetes in areas of deprivation across Cardiff and Vale. • The Health Board has developed a co-ordinated programme of action to reduce smoking in areas/populations where prevalence is highest. It has also taken strong action to introduce enhanced enforcement of no smoking legislation on hospital sites across Cardiff and the Vale of Glamorgan, including introducing innovative approaches that are evidence based but have not been delivered in Cardiff and Vale previously. • • Through our PSB and RPB plans we already prioritise areas of work to tackle inequalities and the refreshed needs assessments for both PSBs and RPB have further identified collective actions. • The future UHB organisational direction agreed at the recent rapid planning event supports the 'shift upstream' by committing to develop an Integrated Community Health System, underpinned by care pathways that begin with prevention; prevention is a 'brilliant basic'. **4. Public Health Priorities to reduce health inequalities.** The Public Health Team have agreed three immediate priorities that will influence health inequalities (and other work that we will need to bring forward when capacity allows). Work to tackle inequalities needs to take place over prolonged time periods. We continue to work with PSB and RPB partnerships to address the three priority areas where we know we can make a significant impact on reducing health inequalities: smoking, vaccination and obesity. The Amplifying Prevention Board, held jointly with Local Authority (LA) partners, provides	

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

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

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

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

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

Report Title:	Update for Women's Health Hubs		Agenda Item No:		3.2.1
Meeting:	Quality Committee	Public	Y	Meeting Date:	02.06.26
		Private			
Lead Executive Title:	Claire Beynon, Executive Director of Public Health				
Report Author/s Title:	Dr. Michael Allum, Consultant in Public Health Medicine				

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

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

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

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

This report outlines activity undertaken to implement the Women's Health Plan over the last 6 months, in particular the commencement of the 'pathfinder' Women's Health Hub.

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

Assurance	Y	**Approval**		**Information/Noting**	

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

The Committee is requested to:

A. **Acknowledge** the update in the Health Board's delivery of the Women's Health Plan for Wales over the last 6 months

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

Where *it's been:*	*CVUHB Women's Health Plan Steering Group*
When *it went:*	*19.05.26*
What *decision was made:*	*For consideration by the Quality Committee for assurance*

Main Report
Background & Current Situation

Background

In December 2024, the National Strategic Clinical Network for Women's Health published the first 'NHS Wales Women's Health Plan' (the Plan). The Plan is a ten-year vision (2025-2035) that outlines an NHS Wales approach to improving the health outcomes for women in Wales.

The 10-year plan followed the publication of the Welsh Government's Quality Statement for Women's and Girls' Health in 2022. This made clear that approaches to healthcare need to change so women can access the care they need in a timely way; that the health service is responsive to their choices and needs and that research and development reflects women and girls' lived experiences.

The Plan will be delivered over ten years, through 64 short, medium and long–term actions. It will follow a life course approach, with a focus on delivery of services from 16 years of age, often an important time of transition within health services for girls. One of the key mechanisms proposed in the Plan to improve service delivery is through the creation of Women's Health Hubs.

The Health Board has a local Women's Health Plan steering and implementation group. This report provides an update on local implementation, following an initial report to the Quality Committee in October 2025 which also provided additional background information.

This update will provide summary of activity undertaken over the last 6 months, including establishing the first Women's Health Hub ('pathfinder' hub), and an overview of national expectations and local activity for financial year 2026-27.

Overview of workstreams during October 2025-April 2026

The priority areas for the initial Women's Health Hubs were set nationally, to be:

- **Menstrual Health** (To include Endometriosis, Dysmenorrhea, Heavy Menstrual Bleeding, PMDD and PCOS).
- **Contraception, Post-natal Contraception and Abortion Care** (To include preconception health, abortion care and initial fertility assessments).
- **Menopause** (To include Premature Ovarian Insufficiency (POI), management of unscheduled bleeding on HRT and Testosterone).

Workstreams were therefore geared towards addressing these three priority areas. An overview of the work undertaken is provided below, including information on the 'pathfinder' hub.

Staff training and development – led by the Primary Community Intermediate Care (PCIC) Academy. A Training Needs Analysis was undertaken to understand the education and training needs of the Primary and Community Care workforce around the three priority areas. These needs were addressed through a programme of funded education and training offers available to individuals, as well as two in-person events. The training offers and in-person events received very positive feedback. Participant data analysis demonstrated uptake from all 9 primary care clusters, with many clusters having training engagement from all practices within their cluster. Staff group attending included GPs, nurses, pharmacists, Allied Health Professional and Advanced Clinical Practitioners. A 3-month impact questionnaire will be sent to participants in June, to find out how training has impacted clinical practice and local service delivery.

Community Health Pathways review

A multidisciplinary programme of work has been undertaken to review and update gynaecology-related Community Health Pathways to ensure they are evidence-based, clinically robust, and aligned with local service provision across Cardiff and Vale.

The work was delivered through collaboration between a Senior Clinical Editor for Community Health Pathways, a PCIC GP, two Consultant Gynaecologists, an

Endometriosis Clinical Nurse Specialist, a PCIC Prescribing Advisor Pharmacist, and consultants in Endocrinology and Biochemistry. This approach ensured both primary and secondary care perspectives were fully integrated.

Key pathways reviewed include heavy menstrual bleeding, intermenstrual and post-coital bleeding, endometriosis, persistent pelvic pain, dyspareunia, vulvodynia, and polycystic ovary syndrome (PCOS). Updates were informed by NICE guidance and relevant specialist standards, including guidance from the British Society for Paediatric & Adolescent Gynaecology and the College of Sexual and Reproductive Healthcare.

While several pathways are progressing towards publication, some remain in development pending further specialist input. This work provides assurance that women's health guidance used in primary care is consistent, evidence-based, and locally appropriate, supporting improved quality and equity of care across Cardiff and Vale.

Gynaecology menopause clinic review
A GP with specialist interest in menopause reviewed referrals and waiting list cases for gynaecology menopause services. The purpose was to address unmet demand and also gather local data on the potential for alternative clinical pathways or processes using primary care. Around 38% of referrals to the menopause clinic were returned to GPs with clinical advice requiring no appointment, suggesting a significant potential for GP-led service delivery. A review of waiting list patients identified process issues to improve (e.g. timely pre-appointment blood tests) to support the patient journey, as well as further training and GP advice opportunities to consider going forwards.

Post-pregnancy contraception service in secondary care
Access to post-pregnancy (including abortion) contraception (e.g. subdermal implants) delivered in secondary care is limited. Optimising access to post-pregnancy contraception should improve patient care and experience and could help reduce unintended subsequent pregnancies. To implement and sustain a post-pregnancy contraception service, 10 midwives and 5 nurses have been trained to fit subdermal implants. To ensure stability of a 7-day service, this has been commenced following completion of training by all individuals, therefore a 6-month evaluation of its impact will be due in Autumn 2026.

'Pathfinder' Women's Health Hub – Cardiff East
Standard GMS services do include menopause care, but there is not currently cluster-based dedicated menopause services. The aim of this pathfinder hub is to have a central dedicated menopause service which includes GPs with extended role (GPwER) and multidisciplinary approach to menopause care. The pathfinder hub is based within Cardiff East primary care cluster at the Maelfa Hub, chosen partly due to being an area of deprivation and therefore serving a community experiencing health inequalities and likely unmet needs in relation to women's health.

The 'pathfinder' Hub provides 30-minute appointments, with up to two sessions per week (typically Tuesday and Wednesday) available. Staffing is by GPs and nurse who are have undertaken additional menopause training, with clinical lead oversight from a secondary care menopause lead. Referrals are received from practices within the Cardiff East cluster, with current inclusion criteria being

‘Individuals aged 40–65 years (perimenopause to post menopause), including those on long-term Hormone Replacement Therapy (HRT) or experiencing ongoing menopausal symptoms.’ Depending on individual patient circumstance, patients would typically be reviewed at baseline, and 3 months and 12 months following initial appointment.

The ‘pathfinder’ Hub commenced on 18th February. Up to 7th May, 71 patients have been referred to the Hub clinical sessions. Only a small number (<10%) were discharged from the cluster clinic following initial assessment, suggesting appropriate referral process for ongoing clinic management. 3-month follow up had not been due at the time of report writing.

In addition to the clinical offer, a wider holistic model is being developed through the Hub. This includes the establishment of a menopause cafe, which takes place on a monthly basis at the Hub location and will be a forum for peer support and informal educational opportunities. There are also patient representatives who are providing a patient ‘sounding board’ to facilitate ongoing feedback and service development.

Evaluation data is being collated through this process, including patient experience data, patient reported outcome data and monitoring of impact on secondary care use. The Hub is currently funded by cluster funds until 31st March 2027. An interim evaluation will be completed in November to inform business case development, with a full evaluation by end of March 2027.

Next steps
Work will continue to implement the Women’s Health plan within Cardiff and Vale University Health Board. In addition to the actions within the Plan, delivery of further specific developments for 2026/27 have been outlined in Key Delivery Expectations, as well as communications from Welsh Government to Health Board:

1. Further expansion of the Women’s Health Hub model by March 2027
2. Bring existing hubs towards uniform provision set out in the Implementation Guide
3. Plan and appropriately prepare for additional services to be delivered by women’s health hubs from April 2027. The areas for further development will be pelvic health; VAWDASV (Violence Against Women; Domestic Abuse; and Sexual Violence)

The in-year expansion of the hub model will be underpinned by the Women’s Health Needs Assessment, due to be finalised by early July. Furthermore, there will continue to be ongoing community engagement and co-production facilitated by C3SC, who’s services have been procured to support this.

The Senior Responsible Officer (or their deputy) and the Clinical Leads will continue to represent the Health Board at national forums related to women’s health plan and will chair the Health Board’s Women’s Health Steering Group.

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

1. Women’s Health Plan for Wales 2025-2035
2. Women’s Health Hub Implementation Guide v4

Strategic Alignment – Shaping Our Future Wellbeing:

Putting People First	X	Providing Outstanding Quality	X

Delivering in the Right Places	X	Acting for the Future	X

Impact Assessment
Risk: No
Safety: No
Financial: Yes
External non-recurrent funding was available for implementation of the Women's health Hubs in 2025/26, and further funding is available for 2026/27. The Health Board bids will be reviewed through Value and Benefits Realisation Group governance.
Workforce: Yes
Non-recurrent revenue funding available, therefore any staffing changes to staff the service are non-permanent.
Legal: No
Reputational: Yes
The Health Board is expected to deliver against the national targets. Risks and issues are logged through the local steering group and reported to Executive SRO as required.
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Report Title: *(needs to match agenda)*	Quality Management System (QMS) Organisational Development Plan		Agenda Item No:		3.3.1
Meeting:	Quality Committee	Public	x	Meeting Date:	02 June 2026
		Private			
Lead Executive Title:	Executive Nurse Director				
Report Author/s Title:	Deputy Executive Nurse Director				

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 Quality Management System Organisational Development Plan indicates that Cardiff and Vale UHB have a strong foundation and clear ambition for an organisation-wide Quality Management System, with several elements already in place.

However, the current baseline shows emerging to developing maturity overall, with further work needed to strengthen consistency, integration, triangulation and delivery before a position of full assurance could be given.

The 12-month delivery plan provides the developments and monitoring through the 5 priorities which provides the overarching plan where a detailed project plan exists

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

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

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

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

- Quality Committee are asked to be **advised** on the content of the development plan
- Quality Committee are asked to **Approve** the Quality Management System Organisational Development Plan
- Quality Committee are asked to recommend the **approval** of the Quality Management System Organisational Development Plan to Board for **Approval** prior to submission to NHS Performance and Improvement

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

***Where** it's been:*	*1. QMS project board* *2. Shaping Our Quality Excellence Programme Board*
***When** it went:*	*1. 22 May 2026* *2. 2 June 2026*
***What** decision was made:*	*1. Approval* *2. Post Quality committee approval*

Main Report
Background & Current Situation

This paper sets out Cardiff and Vale University Health Board's proposed Quality Management System (QMS) Organisational Development Plan, describing both the organisation's long-term aspiration for a coherent, organisation-wide QMS and the current baseline position from which this development plan will proceed.

The Health Board's ambition is to establish a single, organisation-wide Quality Management System that brings together quality planning, quality improvement, quality assurance and quality control into one integrated way of working. The intention is that the QMS will not operate as a separate programme, but instead become embedded within the organisation's governance, planning, improvement and operational processes. Quality management would support better organisational understanding, more consistent decision-making, improved alignment between priorities and delivery, and greater confidence in how risks and outcomes are monitored and managed. The proposed approach is explicitly aligned to the Duty of Quality (Wales), HIW inspection domains, and wider NHS Wales governance and assurance frameworks.

The Organisational Development Plan describes the future QMS as one that is clearly understood across the organisation, uses common language and definitions, is aligned to strategic intent, and is proportionate and supportive rather than burdensome. It also envisages a system enabled by leadership, capability, intelligence and culture, with clear links across all four quality domains and with learning embedded into everyday delivery and decision-making.

In relation to **quality planning**, the development plan sets out an aspiration that strategic priorities, annual plans, IMTP commitments, transformation programmes and service developments should all be explicitly aligned to organisational quality aims. Quality should be designed into services from the outset, with systematic consideration of the six domains of quality, and with clear articulation of intended outcomes, risks, dependencies, benefits and success measures. The development actions proposed include baseline assessment and maturity analysis, mapping of current planning and governance arrangements, agreement of core QMS components and expectations, and the introduction of standard quality planning measures and KPIs.

For **quality improvement**, the development plan describes an ambition for improvement to become a routine organisational capability rather than a series of isolated projects. Improvement activity should be aligned to organisational priorities, informed by intelligence and feedback, and supported through a coherent operating model, consistent methods and robust measurement. Proposed actions include testing and refining the QMS improvement approach through a prototype team, using maturity matrix outputs to identify priorities, developing an agreed portfolio of internal improvement projects, establishing learning loops from prototype activity, and building workforce capability in structured improvement methods.

For **quality assurance**, the development plan describes the desired future state as one in which the Board and executive leaders receive clear, triangulated and forward-looking assurance on quality. Assurance should focus more on system performance, risk, trends and action, rather than retrospective compliance alone. The development plan proposes further work to aggregate maturity assessments across the organisation, develop a clinical governance framework that provides assurance from frontline to Board, establish benchmarking and standard KPIs, support Board development, and ensure that RAG ratings are supported by narrative and evidence.

For **quality control**, the development plan sets out an expectation that core clinical and corporate processes should be reliable, standardised where appropriate, and controlled in a proportionate, risk-based and improvement-focused way. Existing controls such as incident management, audits and reviews should support learning rather than blame, with clear ownership and better integration into the wider QMS intelligence framework. Planned

actions include mapping current control and assurance mechanisms, reducing duplication, strengthening links between risk, incident, audit and improvement systems, and increasingly targeting control activity toward organisational risks and priorities.

The Quality Management System (QMS) Organisational Development Plan also recognises that successful implementation depends on a wider **enabling system**. This includes leadership, organisational culture, staff capability, governance arrangements and accessible data. The aspiration is for staff to experience an organisation that supports learning, psychological safety and improvement, with leaders modelling openness and curiosity, and with improvement, human factors and data literacy seen as core skills. Planned enabling actions include education and communication workstreams, development of a capability framework aligned to QMS roles, organisation-wide engagement including a QMS launch event, and ongoing refinement of the model based on learning and feedback.

The **current state assessment** has been informed by baseline questionnaires across Clinical Boards, reflection against the All-Wales QMS Maturity Matrix, and review of existing governance, improvement and assurance arrangements. The report concludes that Cardiff and Vale currently demonstrate **emerging to developing maturity** across the QMS domains. It identifies clear strengths in strategic intent, commitment and expertise, but also highlights opportunities to improve coherence, consistency, alignment and system integration.
The baseline position is summarised as follows:

- **Quality Planning** is assessed as **developing**, with strong strategic intent but inconsistent translation into operational quality goals.
- **Quality Improvement** is assessed as **emerging**, with pockets of good practice and capability but variable activity that is not yet consistently aligned to organisational priorities.
- **Quality Assurance** is assessed as **developing**, with a significant volume of assurance information available, but variable triangulation and a risk of duplication and retrospective focus.
- **Quality Control** is assessed as **developing**, with established compliance mechanisms that are sometimes experienced as burdensome and not always clearly linked to improvement or risk reduction.
- **Enabling factors** are present, including a strong commitment to quality and safety, but capability, data accessibility and protected time for improvement remain variable.

Overall, the Quality Management System (QMS) Organisational Development Plan indicates that the organisation has not reached a position of full maturity or assurance. The current position is best understood as one of **development and consolidation**, with a strong foundation and clear ambition, but with further work required to create a genuinely integrated and consistent organisational QMS.

The report therefore proposes a **12-month delivery plan** focused on establishing the foundations of the QMS rather than attempting whole-system transformation at pace. The five priorities are:

1. **Establish a clear organisational QMS framework**
2. **Strengthen quality planning and alignment**
3. **Build improvement capability and focus**
4. **Improve quality assurance and intelligence**
5. **Improve quality control**

These priorities are intended to deliver a shared organisational understanding of how quality is managed, strengthen the line of sight between strategy and frontline outcomes, increase staff capability for improvement, enhance confidence in quality risk management, and ensure that control mechanisms are more meaningful, proportionate and improvement focused.

In conclusion the Quality Management System (QMS) Organisational Development Plan is a clear strategic ambition and a credible delivery plan, but where further work is required to strengthen consistency, triangulation, capability and integration across the whole system. The overall position is therefore best described as **Advise**, reflecting that the organisation has a solid foundation and defined next steps, but is not yet in a position to provide full assurance on QMS maturity.

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

1. Quality Management System (QMS) Organisational Development Plan document
2. Quality Management System (QMS) Organisational Development Plan Presentation

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
Not applicable
Safety: No
Not applicable
Financial: No
Not applicable
Workforce: No
Not applicable
Legal: No
Not applicable
Reputational: No
Not applicable
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Not applicable
Equality & Health: No
Not applicable
Decarbonisation: No
Not applicable
Welsh Language: No
Not applicable

Cardiff & Vale UHB

Quality Management System Organisational Development Plan

July 2026

1.0 Our Aspiration

What good looks like (our overall QMS vision)

Cardiff and Vale UHB will operate a single, organisation wide Quality Management System (QMS) that provides clarity, consistency and confidence in how quality is planned, improved, assured and controlled. The QMS is not a programme or framework in isolation, but a way of working embedded across the whole organisation, which will be integrated with governance, planning, improvement and assurance processes, supported by strong leadership, capability and intelligence. It will provide an integrated view of Cardiff and Vale UHB and facilitate better decision-making.

The QMS will not exist as a standalone programme, but as a way of working – designed to support Clinical Boards, Corporate functions and leaders throughout CAV to understand the operating landscape and make great decisions for forward focus and has clear alignment to:

- Duty of Quality (Wales)
- HIW inspection domains
- NHS Wales governance and assurance frameworks

The aspirational QMS will be:

- Clearly understood, with common language and definitions
- Aligned to strategic intent
- Proportionate and supportive rather than burdensome
- Enabled by strong governance, capability, intelligence and culture
- Explicitly linked across the four domains
- Embedded into planning, delivery and everyday decision-making
- Supportive to organisation learning and development

1.1 Quality Planning

Our Aspiration

Our Organisational Strategic priorities, Annual Plans, IMTP commitments, transformation programmes and service developments are explicitly aligned to agreed organisational quality aims. Quality is designed into services from the outset, with systematic consideration of the six domains of quality (Safe, Timely, Effective, Efficient, Equitable, and Patient-Centred).
Planning processes clearly articulate intended quality outcomes, risks, dependencies, benefits and measures of success.

What this looks like in practice

- Strategic priorities, IMTP commitments, transformation programmes and service developments are explicitly aligned to agreed organisational quality aims.
- There is alignment between organisational priorities, clinical board plans and improvement activity
- Quality is systematically considered through:
    - Quality impact assessment
    - Risk and dependency consideration
    - Workforce, digital and infrastructure planning
- Planning processes clearly articulate:
    - Intended quality outcomes
    - Measures of success
    - Ownership and accountability

How we plan to get there

- Baseline assessment and maturity analysis using questionnaires and the All-Wales QMS Maturity Matrix
- System mapping of current planning and governance processes to understand variation and duplication
- Development and agreement of core QMS components, including quality planning expectations and templates
- Integration of QMS learning into annual and ongoing planning cycles, informing priorities and monitoring progress
- Establishment of a standard suite of quality planning measures and KPIs aligned to organisational quality objectives

1.2 Quality Improvement

Our Aspiration

Improvement is a core organisational capability and a routine part of everyday work; CAV has support in facilitating and completing improvement work through the Shaping Change team. Improvement

activity is aligned to organisational priorities, informed by quality intelligence, patient and staff feedback which are utilised to guide focussed improvement activities.
Improvement is supported through a clear operating model, consistent methods and strong measurement.

What this looks like in practice

- A coherent improvement operating model (The CAV Way) covering:
    - Identification and prioritisation of improvement opportunities
    - Access to improvement expertise and coaching
    - Measurement and evaluation
    - What works well is Spread and Scaled
- Clear line of sight from harm, waste and variation to improvement action
- Visible executive and clinical leadership for improvement

How we plan to get there

- Establishment of prototype team to test and refine the QMS improvement approach in practice
- Use of maturity matrix outputs to identify priority improvement opportunities
- Agreement of a set of internal development and improvement projects aligned to quality priorities
- Delivery of agreed set of internal development and improvement projects
- Creation of structured learning loops to ensure learning and insight from the Prototype informs the development of the wider CAV QMS and vice versa
- Quality Improvement (QI) capability assessment across workforce
- Building capacity and capability in improvement methods through targeted engagement, education and ongoing support including use of structured methodologies (eg PDSA cycles)
- Improvement priorities linked to strategic goals, risk and performance
- Measurable improvement outcomes over time

1.3 Quality Assurance

Our Aspiration

Board and executive leaders receive clear, triangulated, and forward looking assurance on quality. Assurance focuses on system performance and risk, enabling early intervention and learning rather than retrospective compliance. Internal and external assurance methods are aligned and proportionate, and themes from multiple sources are routinely brought together to provide system-wide intelligence.

What this looks like in practice

- Integrated dashboards combining outcomes, experience, safety and operational intelligence
- Clear escalation routes and accountabilities for quality risks
- Board discussions are focused on themes, trends and action
- Assurance is clearly linked to improvement and control activity

How we plan to get there

- Completion and aggregation of QMS maturity assessments across clinical boards and corporate teams to build an organisation wide assurance picture
- Development of a clinical governance framework that provides assurance from floor to Board
- Establishment of benchmarking and standard KPIs to support comparative and trend based assurance
- Board development activity delivered in partnership with NHS Wales P&I, followed by ongoing updates
- RAG ratings supported by narrative and evidence
- Focus on risk mitigation and improvement actions, not just status

1.4 Quality Control

Our Aspiration

Core clinical and corporate processes are reliable, standardised where appropriate and effectively controlled. Compliance activity is proportionate, risk based and focused on maintaining safe, high-quality day-to-day services.

What this looks like in practice

- Clear standards and operating procedures with regular SOP reviews
- Incident management, audits, reviews provide opportunities for active learning, not blame
- Controls have clear ownership
- Core processes are located and managed as close as possible to place of operation
- Controls include clear standards:
  - Risk and issue logs
  - Audit feedback loops
  - Action and decision tracking
- Datix, audit and risk information are integrated into the wider QMS intelligence framework

How we plan to get there

- Mapping current control and assurance mechanisms to the QMS framework to identify overlaps and gaps
- Strengthening links between risk, incident, audit and improvement systems to improve learning and reduce duplication
- Alignment of quality control activity with organisational quality risks and priorities
- Use of QMS intelligence to refine and prioritise control activity over time

1.5 Enabling System

Our Aspiration

Leadership, culture, capability, governance and data collectively enable the QMS to function effectively. Staff experience an organisation that supports learning, improvement and psychological safety.

What this looks like in practice

- Leaders role-model expectations, behaviours, curiosity, openness and learning
- Improvement, human factors and data literacy are core skills
- Psychological safety supports speaking up and improvement
- Protected time for improvement activity
- Governance structures reinforce, rather than fragment, quality management
- Data and intelligence are accessible, timely and meaningful
- Both quantitative and qualitative intelligence add value
- Environmental sustainability considerations run through everything we do
- Our work integrates the principles of Value Based Healthcare

How we plan to get there

- Establishment of education, training, engagement and communication workstreams to support consistent understanding of the QMS
- Development of a capacity and capability framework aligned to QMS roles and expectations
- Organisation wide engagement activities, including a QMS launch event, supported by clear communications
- Ongoing refinement of the QMS using learning from the prototype, maturity assessments and feedback loops

2. Current State Assessment

Approach

The current state of the organisational QMS has been assessed through:

- Completion of initial baseline questionnaires across all Clinical Boards
- Further application of and internal reflection against the All-Wales QMS Maturity Matrix across all Clinical Boards and Corporate functions
- Review of existing governance, improvement and assurance arrangements

Based on the initial Baseline exercise, overall, CAV demonstrates emerging to developing maturity across the QMS domains, with clear strengths in intent and expertise, and opportunities to improve coherence, alignment and consistency.

This baseline will be firmed up with more detail using the Maturity Matrix assessments, together with System Mapping (where relevant) to shape and guide future development focus.

Summary Initial Baseline Assessment (To be followed up and triangulated with completion of the Maturity Matrix across all departments in CAV):

QMS Component	Current State (High-Level)
Quality Planning	Strong strategic intent but inconsistent translation into operational quality goals. Quality considerations present but not always explicit or systematic. Developing.
Quality Improvement	Pockets of good practice and capability. Improvement activity often project-based, variable and not consistently aligned to organisational priorities. Emerging.
Quality Assurance	Significant volume of assurance information, but variable triangulation and synthesis. Risk of duplication and retrospective focus. Developing.
Quality Control	Established compliance mechanisms, though experienced by staff as burdensome and not always clearly linked to improvement or risk reduction. Developing.
Enablers	Strong commitment to quality and safety. Variable improvement capability, data accessibility and protected time for improvement.

3. Priorities and 12-Month Delivery Plan

The focus for the next 12 months will be on embedding the foundations of a single, coherent organisational QMS, rather than attempting to do everything at once.

Priority 1: Establish a Clear Organisational QMS Framework

What will change:

- Define and agree a single, clear QMS framework for the UHB, aligned to the four quadrants and key enablers.
- Clarify roles, responsibilities and interfaces between planning, improvement, assurance and control.

Key Actions:

- Finalise and communicate a single QMS framework aligned to NHS Wales guidance
- Embed the framework within governance, planning and operational processes
- Use a consistent language and visual QMS model across the organisation

Outcome:

- Shared understanding of “how quality works” in Cardiff and Vale UHB

Priority 2: Strengthen Quality Planning and Alignment

What will change:

- Explicit quality aims and priorities are embedded into business planning and service redesign.

Key Actions:

- Agree a small number of organisational quality aims
- Embed quality impact assessment into planning and decision-making
- Strengthen patient and public involvement in planning at am operational level
- Embed QMS expectations within service and business planning
- Use standardised templates for defining aims, scope, risks, benefits and measures
- Strengthen co-production and stakeholder engagement in planning

Outcome:

- Clear line of sight from strategy to frontline quality outcomes

Priority 3: Build Improvement Capability and Focus

What will change:

- Improvement effort becomes more aligned, supported and sustainable.

Key Actions:

- Define and embed an improvement operating model
- Continue to target improvement support to organisational priorities
- Expand improvement capability through targeted development and coaching

Outcome:

- Increased staff confidence and capability to improve care

Priority 4: Improve Quality Assurance and Intelligence

What will change:

- Assurance becomes more integrated, risk-based and forward-looking.

Key Actions:

- Strengthen triangulation of quality data, intelligence and narrative
- Create, simplify and align dashboards and reporting
- Strengthen Board-level quality conversations

Outcome:

- Greater confidence in understanding and managing quality risks

Priority 5: Improve Quality Control

What will change:

- Compliance processes become conscious, embedded, meaningful and improvement-focused.

Key Actions:

- Review audit and assurance activity processes
- Align audits and controls with key risks and priorities
- Strengthen learning from incidents and reviews

Outcome:

- Improved alignment; increased learning and impact

Quality Management System Organisational Development Plan

Priority Number	Aims	Actions	Outcomes	Completion Date	Responsible	Status
Priority 1: Establish a Clear Organisational QMS Framework	Define and agree a single, clear QMS framework for the UHB, aligned to the four quadrants and key enablers. Clarify roles, responsibilities and interfaces between planning, improvement, assurance and control.	• Finalise and communicate a single QMS framework aligned to NHS Wales guidance • Embed the framework within governance, planning and operational processes • Use a consistent language and visual QMS model across the organisation	Shared understanding of "how quality works" in Cardiff and Vale UHB	Quarter 2	SROs	In Progress
Priority 2: Strengthen Quality Planning and Alignment	Explicit quality aims and priorities are embedded into business planning and service redesign	• Agree a small number of organisational quality aims • Embed quality impact assessment into planning and decision-making • Strengthen patient and public involvement in planning at an operational level • Embed QMS expectations within service and business planning • Use standardised templates for defining aims, scope, risks, benefits and measures • Strengthen co-production and stakeholder engagement in planning	Clear line of sight from strategy to frontline quality outcomes	Quarter 4	SROs CB Triumvirates Strat Planning Team	Not Started
Priority 3: Build Improvement Capability and Focus	Improvement effort becomes more aligned, supported and sustainable.	• Define and embed an improvement operating model • Continue to target improvement support to organisational priorities • Expand improvement capability through targeted development and coaching	Increased staff confidence and capability to improve care	Quarter 4	Shaping Change Team	In Progress
Priority 4: Improve Quality Assurance and Intelligence	Assurance becomes more integrated, risk-based and forward-looking.	• Strengthen triangulation of quality data, intelligence and narrative • Create, simplify and align dashboards and reporting • Strengthen Board-level quality conversations	Greater confidence in understanding and managing quality risks	Quarter 4	Project Team	Opened
Priority 5: Improve Quality Control	Compliance processes become conscious, embedded, meaningful and improvement focused.	• Review audit and assurance activity processes • Align audits and controls with key risks and priorities • Strengthen learning from incidents and reviews	Improved alignment; increased learning and impact	Quarter 3	SROs Corporate Governance Team Quality Governance structures	Progressing

QMS Organisational Position Statement and Development Plan Guidance

NHS Wales Performance and Improvement

20 January 2026

As part of the Duty of Quality under the *Health and Social Care (Quality & Engagement) (Wales) Act 2020*, every Health Board and Trust in Wales is required to adopt a Quality Management System (QMS).

This involves fostering a dynamically interconnected whole organisation quality approach, linking finance, performance and quality in the delivery of care. The goal is that the delivery and assurance of high-quality care is aligned to strategy, underpinned by documented processes, procedures and responsibilities, and fully embedded in organisational culture.

To provide assurance to the Welsh Government that this is the case we are asking all NHS Wales organisations to provide:

1. **An early position statement (by 1 April 2026)**

This will outline progress to date and the current position with the development and implementation of a QMS. We fully appreciate that NHS organisations across Wales will be at different stages of their QMS journey, the important point at this stage is that there is a focus on a quality approach supported by the stewardship of the Board and leadership of the executive team.

2. **An organisational development plan (by 31 July 2026)**

This should provide clarity about the agreed overall vision for the organisation's QMS and its specific goals and plans to achieve them for 2026/2027. It should include detail about the steps the organisation is planning to take to move towards that vision and embed a QMS.

Early Position Statement

To be submitted to NHS Wales Performance and Improvement by **1 April 2026.** As part of this early position statement, organisations should focus on the Duty of Quality Enablers, outlining the work already undertaken to provide the right foundations for a QMS and how they intend to continue to work on these as they embed a QMS. Considering the following questions may be helpful:

1. What knowledge, skills and infrastructure are being put in place to support the development of an organisational QMS?
2. How are leadership, workforce and culture helping to drive the organisation's approach?
3. What is the strategy to communicate the vision of a QMS to the wider workforce and the role all staff play in its delivery?
4. How are you developing your overall quality approach?

Organisational development plan

To be submitted to NHS Wales Performance and Improvement by **31 July 2026.**

1. Describe your aspirational state

The operational QMS may look slightly different in each organisation. For each of the four QMS quadrants (quality planning, quality improvement, quality assurance and quality control) and the key enablers, outline the ideal future state for the organisation. This should paint the unique picture of what good looks like for a QMS within the specific context of your organisation.

2. Assess the current state

Using any methods deemed appropriate, assess the current state of the organisational QMS. You may want to consider using the All-Wales QMS Maturity Matrix.

3. Identify the priorities and explain how your organisation will make progress towards embedding a QMS over the next 12 months.

Any queries, please contact NHSPI.Qualityandsafety@wales.nhs.uk

GIG
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Performance
and Improvement

QMS Organisational Development & Implementation Plan

Why this work matters

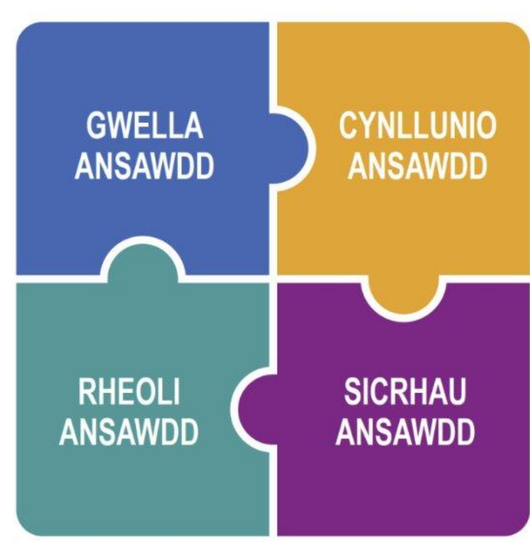
Requirement to establish an organisation-wide QMS aligned to NHS Wales expectations

Opportunity to improve:

- clarity
- consistency
- decision-making

Move from:

- Fragmented assurance & improvement
  → to a single, coherent system



What good looks like

- Single, organisation-wide Quality Management System
- Embedded into:
    - Planning
    - Improvement
    - Assurance
    - Control
- Common language and approach
- Supports:
    - Better decisions
    - improved outcomes
    - organisational learning

Current Position

Quality Planning

- Strong strategic intent but inconsistent translation into operational quality goals.
- Quality considerations present but not always explicit or systematic.
- Developing.

Quality Improvement

- Pockets of good practice and capability.
- Improvement activity often project-based, variable and not consistently aligned to organisational priorities.
- Emerging.

Quality Assurance

- Significant volume of assurance information, but variable triangulation and synthesis.
- Risk of duplication and retrospective focus.
- Developing.

Quality Control

- Established compliance mechanisms, though experienced by staff as burdensome and not always clearly linked to improvement or risk reduction.
- Developing.

Enablers: Strong commitment to quality and safety. Variable improvement capability, data accessibility and protected time for improvement.

QMS Implementation Priorities

QMS Implementation Priorities

- Establish QMS Framework
- Strengthen Quality Planning
- Build Improvement Capability
- Improve Assurance & Intelligence
- Improve Control Processed

Delivery Approach

3 core components to delivery is

- Phased
- Focused
- Practical

=

- Build capacity and engagement
- Use feedback, intelligence and assessment
- Standardise key frameworks, templates, measures and expectations
- Test & refine approaches
- Embed QMS into existing governance
- Focus on small number of priority areas
- Utilise baseline assessment & QMS maturity
- Build the foundation first

In Conclusion

The Organisational plan is delivering through
- incremental implementation,
- organisational alignment,
- learning from practice, and
- continuous refinement

Recommendation

Quality Committee are asked to
- be **advised** on the content of the development plan
- **Approve** the Quality Management System Organisational Development Plan
- recommend the **approval** of the Quality Management System Organisational Development Plan to Board for **Approval** prior to submission to NHS Performance and Improvement

Report Title:	*Theatres Together*		Agenda Item No:		3.4.1
Meeting:	Quality Committee	Public	X		02/06/26
		Private			
Lead Executive Title:	Chief Operating Officer				
Report Author/s Title:	Director of Operational Planning and Performance				

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]

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

Overall, strong and sustained progress is being demonstrated across all tranches, with a clear shift from foundational improvements to embedding long-term cultural change, operational efficiency, and workforce sustainability within theatre services. Significant progress has been made across all recommendations with 34 of the initial 66 recommendations being completed.

Since the last update, the Theatres Together project undertook a cultural survey across the perioperative team. Demonstrable positive improvements include:

- Significant steps forward have been taken to support a positive growth culture across theatres in Cardiff and Vale UHB.
- On comparison to the staff surveys taken in 2024 and 2025 there has been improvement across the range of measures.
- Staff are feeling increasingly safe and able to ask for help and supported to raise concerns.
- There is a returning sense of pride about working in theatres in Cardiff and Vale.

The qualitative feedback provided further detail around aspects of working in theatres that need further improvement. These remain the focus of other ongoing project recommendations and workstreams including:

- Finding effective communication systems that work across various teams.
- Developing efficient theatres with positive and effective feedback loops that are visible to the teams.
- Improvements in infrastructure – IT, facilities and estates.

In January 2026, ownership of the HSDU improvement plan transferred to the Theatres Together programme to ensure stronger alignment with theatre-wide improvement activity and to support continued delivery. This approach reflects the integration of HSDU as a defined workstream within the overall programme structure.

Progress to date:
- **10 recommendations** have been successfully completed
- **12 recommendations** remain in progress
- **1 recommendation** has been de-scoped.

Overall, good progress has been made since transition into the Theatres Together programme, with a structured approach to tracking delivery and prioritising actions across the remaining recommendations. Risks and issues to delivery, including ongoing refurbishment work and workforce, are being mitigated through dedicated support.

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

Assurance		Approval		Information/Noting	X

Recommendations *Recommendations should be clear, actionable, and aligned to the AAA summary above.*	
Quality Committee are asked to: A. **NOTE** the updates on the Theatre Together Programme	
Governance Route *(please list all other Committee/Groups this report has been to)*	
***Where** it's been:*	*Public Board*
***When** it went:*	*28th May 2026*
***What** decision was made:*	*TBC*
Main Report *Background & Current Situation*	
Appendices: *(List any appendices that will accompany this report).*	
• Theatres Together Improvement Plan V1.4.1	

Strategic Alignment – Shaping Our Future Wellbeing:			
Putting People First	X	Providing Outstanding Qua	X
Delivering in the Right Places		Acting for the Future	

Impact Assessment
Risk: Yes
Theatres review highlighted potential risks. Actions within the submitted improvement plan respond accordingly
Safety: Yes
Theatres review highlighted potential safety concerns. Actions within the submitted improvement plan respond accordingly
Financial: Yes
Actions in place for any financial impact. Actions within the submitted improvement plan respond accordingly
Workforce: Yes
Theatres review highlighted significant workforce constraints. Actions within the submitted improvement plan respond accordingly
Legal: No
Reputational: Yes
Theatres review highlighted potential reputational concern. Actions within the submitted improvement plan respond accordingly
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Report Title:	Pathway to Safer Beginnings (Wales): Gap Analysis and Proposed Three-Year Improvement Programme		Agenda Item No:		3.4.2
Meeting:	Quality Committee	Public	X	Meeting Date:	2nd June 2026
		Private			
Lead Executive Title:	Jasons Roberts				
Report Author/s Title:	Abigail Holmes				

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)*

This paper provides advisory assurance that Cardiff and Vale UHB has a credible and broadly aligned response to *Pathway to Safer Beginnings (Wales)*, with clear strengths in core governance, quality of care, and existing safety systems, but also identifies material gaps that require sustained executive oversight over the next three years, particularly in workforce capacity, theatre and neonatal resilience, perinatal mental health provision, family-centred incident response, and the consistent use of feedback and inequalities data to drive measurable.

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	

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

The Committee is asked to:

A. **Note** the work towards full implementation of the Pathways to Safer Beginnings Priorities.

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

1. Purpose

To provide the Quality Committee with assurance on Cardiff & Vale University Health Board's (C&V UHB) alignment with the Pathway to Safer Beginnings (Wales) national priorities, and to present a proposed gap analysis and three-year improvement programme (2026–2029).

2. Background and Context

The *Pathway to Safer Beginnings* sets out the findings of the National Assurance Assessment of Maternity and Neonatal Services in Wales and identifies eight national priorities requiring sustained system-wide action over a minimum three-year period.

The programme reflects persistent and well-evidenced risks across Wales relating to clinical safety systems, workforce capacity, incident response, mental health provision, neonatal commissioning, and the consistent use of experience and feedback to drive improvement.

C&V UHB is required to demonstrate a clear local response that:

- Is aligned to national expectations
- Is measurable and time-bound
- Provides visible Board-level assurance
- Improves safety, outcomes, experience and equity

3. Gap Analysis and Proposed Programme of Work

Priority 1 – Joined up National Perinatal Leadership (Status: Partial)

Gap summary:

- Local governance is established but requires clearer articulation of escalation routes and alignment to emerging national oversight structures.
- Performance reporting is not yet fully consolidated into a single perinatal quality and safety view.

Year 1 (2026/27) actions:

- Refresh perinatal governance framework from Board to front line, including escalation thresholds.
- Implement a single Safer Beginnings performance dashboard covering safety, staffing, flow, experience and equity.

Quality and safety measures:

- Timely escalation and closure of safety risks
- Board visibility of perinatal risk and performance

Priority 2 – Universal Offer of High-Quality Care (Status: On track)

Gap summary:

- Variation remains in documentation and quality of birth discussions prior to discharge.
- Continued assurance required on sustainability of UNICEF UK Baby Friendly Initiative (BFI) standards.

Year 1 actions:

- Audit and standardise birth discussion documentation and parent information.
- Agree and deliver a refreshed BFI delivery plan with defined milestones, aim for reaccreditation by end of 2026

Measures:

- Birth discussion completion and quality audits data to be presented at the quarterly Safer beginnings programme board.
- BFI accreditation progress and compliance

Priority 3 – Urgent Attention to Critical Clinical Safety Systems (Status: Partial)

Gap summary:

- Core systems in place, but ongoing assurance needed to demonstrate sustained effectiveness and learning.

Year 1 actions:

- Maintain routine audit of triage response times and induction of labour (IOL) flow.
- Quarterly thematic review of harm, delay and escalation events.

Measures:

- Triage waiting times and safety incidents
- IOL delays, capacity and outcomes

Priority 4 – Enough Staff and the Right Spaces to Care Safely (Baseline to be confirmed)

Key risks:

1. Purpose

To provide the Quality, Safety and Experience (QSE) Committee with assurance on Cardiff & Vale University Health Board's (C&V UHB) alignment with the Pathway to Safer Beginnings (Wales) national priorities, and to present a proposed gap analysis and three-year improvement programme (2026–2029).

2. Background and Context

The *Pathway to Safer Beginnings* sets out the findings of the National Assurance Assessment of Maternity and Neonatal Services in Wales and identifies eight national priorities requiring sustained system-wide action over a minimum three-year period.
The programme reflects persistent and well-evidenced risks across Wales relating to clinical safety systems, workforce capacity, incident response, mental health provision, neonatal commissioning, and the consistent use of experience and feedback to drive improvement.

C&V UHB is required to demonstrate a clear local response that:

- Is aligned to national expectations
- Is measurable and time-bound
- Provides visible Board-level assurance
- Improves safety, outcomes, experience and equity

3. Gap Analysis and Proposed Programme of Work

Priority 1 – Joined up National Perinatal Leadership (Status: Partial)

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Year 1 (2026/27) actions:

- Refresh perinatal governance framework from Board to front line, including escalation thresholds.
- Implement a single Safer Beginnings performance dashboard covering safety, staffing, flow, experience and equity.

Quality and safety measures:

- Timely escalation and closure of safety risks
- Board visibility of perinatal risk and performance

Priority 2 – Universal Offer of High-Quality Care (Status: On track)

Gap summary:

- Variation remains in documentation and quality of birth discussions prior to discharge.
- Continued assurance required on sustainability of UNICEF UK Baby Friendly Initiative (BFI) standards.

Year 1 actions:

- Audit and standardise birth discussion documentation and parent information.
- Agree and deliver a refreshed BFI delivery plan with defined milestones, aim for reaccreditation by end of 2026

Measures:

- Birth discussion completion and quality audits data to be presented at the quarterly Safer beginnings programme board.
- BFI accreditation progress and compliance

Priority 3 – Urgent Attention to Critical Clinical Safety Systems (Status: Partial)

Gap summary:

- Core systems in place, but ongoing assurance needed to demonstrate sustained effectiveness and learning.

Year 1 actions:

- Maintain routine audit of triage response times and induction of labour (IOL) flow.
- Quarterly thematic review of harm, delay and escalation events.

Measures:

- Triage waiting times and safety incidents
- IOL delays, capacity and outcomes

Priority 4 – Enough Staff and the Right Spaces to Care Safely (Baseline to be confirmed)

Key risks:

- Workforce gaps, sickness and skill-mix pressures
- Theatre capacity and resilience
- Sustainability of time-limited specialist roles

Year 1 actions:

- Update Birthrate+ (assessment ongoing) and triangulate with acuity and complexity.
- Obstetric and anaesthetic capacity and job planning review.
- Maternity theatre capacity and utilisation review.

Measures:

- Staffing fill rates and red flag events
- Theatre access delays and avoidable harm

Priority 5 – Mental Health Support for Women, Families and Staff (Baseline to be confirmed)

Key risks:

- Gaps in provision for mild to moderate needs
- Limited psychology input in clinical settings
- Inconsistent trauma-informed practice

Year 1 actions:

- Map current perinatal mental health provision and waiting times.
- Implement trauma-informed training across maternity and neonatal services.
- Review funding streams, women's wellbeing midwife providing care to women suffering from mild to moderate mental health concerns not replaced due to financial constraining by need reconsideration.

Measures:

- Referral-to-assessment times
- Staff and service-user experience feedback

Priority 6 – Improved Planning and Commissioning for Neonatal Care (In complete / requires JCC alignment)

Key risks:

- Transitional care capacity constraints
- Neonatal transport delays
- Out-of-area transfers

Year 1 actions:

- Baseline review of neonatal capacity, transfers and escalation.
- Prepare local readiness for national cot and bed locator.

Measures:

- Transfer rates and delays
- Occupancy and escalation days

Priority 7 – Learning from Reviews with Families Involved (Incomplete)

Key risks:

- Variation in family involvement and timeliness of investigations
- Delayed learning and action closure

Year 1 actions:

- Implement a local perinatal incident response SOP aligned to national direction.
- Strengthen family liaison and restorative approaches.

Measures:

- Time to completion of reviews
- Evidence of family involvement and learning implementation

Priority 8 – Listening, Understanding and Improving Through Real Feedback (Baseline to be confirmed)

Key risks:

- Feedback not consistently translated into service change
- Limited evaluation of impact on inequalities

Year 1 actions:

- Establish a single feedback-to-improvement pipeline (women, families and staff). Patient Experience services 1-5. 1-3 already in use.
- Define and test priority inequalities improvement initiatives.

Measures:

- Action closure rates from feedback
- Experience and outcome differentials

4. Governance and Reporting

- Establish a Safer Beginnings Programme Board (quarterly), aligned to the Clinical Board and QSE Committee chaired by EDoN
- Eight priority workstreams with named SROs.
- Monthly highlight report and quarterly deep dives to QSE.

5. Risks and Dependencies

- Workforce availability and financial constraints
- Estates and theatre capacity limitations
- Dependence on national commissioning decisions and specifications
- Data quality and digital interoperability

These risks will be tracked on the Clinical Board risk register with agreed mitigations.

6. Finance and Resources

No new investment is requested.

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

Strategic Alignment – Shaping Our Future Wellbeing:

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

Impact Assessment

Risk: No

Safety: No

Financial: No
Workforce: Yes
Future workforce growth may be required to implement all of the priority actions.
Legal: No
Reputational: No
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: No
Decarbonisation: No
Welsh Language: No

[Type here]

Report Title: *(needs to match agenda)*	JACIE Inspection Update			Agenda Item No:	*3.4.3*
Meeting:	Quality Committee	Public	x	Meeting Date:	02/06/26
		Private			
Lead Executive Title:	Paul Bostock - Chief Operating Officer				
Report Author/s Title:	Jessica Castle – Director of Operations Specialist Services Katie Innes – Strategic Planning Manager				

Report Focus Summary – **AAA Framework:** *The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here: NHS Triple A Guide*
ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*
Following the accreditation visit on 18th and 19th September 2025, the decision was taken by JACIE to defer reaccreditation of the South Wales Blood and Marrow Transplant Programme pending confirmation of remedial and corrective actions. We are required to respond to JACIE by 8th July 2026 when a further decision on accreditation will be made. Should our response to the JACIE report be unsatisfactory, there is a risk that accreditation could be withdrawn. This would result in the cessation of both the South Wales Blood and Marrow Programme and the CAR-T Programme – meaning these services would no longer be delivered in Wales. This would have a severe adverse impact on haematological cancer care across the SWBMT Programme catchment area, which accounts for ~80% of the Welsh population. The significance of this is underlined by the fact that for many patients with haematological malignant and non-malignant conditions (such as bone marrow failure syndromes), BMT and CAR-T represent the only means of cure. Patients in Wales would therefore be consigned to suboptimal clinical outcomes, including shortened survival, for conditions that are potentially curable. There would also be a serious adverse impact on the delivery of ATMPs in Wales and the ambition of NHS Wales/Welsh Government to be a leader in this field.
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)*** *To confirm the action Members are being asked to take considering the AAA Framework*					
Assurance	x	**Approval**		**Information/Noting**	
Recommendations *Recommendations should be clear, actionable, and aligned to the AAA summary above.*					
The Committee are asked to note the significant risk and ongoing mitigating actions being progressed across the SWBMT Programme, Specialist Services Clinical Board, the wider Health Board and partners.					
Governance Route ***(please list all other Committee/Groups this report has been to)***					
***Where** it's been:*	*In various formats – Tertiary Services Development Group, VBRG, SLT, F&P Committee and previous updates to Quality Committee*				
***When** it went:*	*F&P – 20/05/26*				
***What** decision was made:*	*Support for revenue case and agreement to submit to JCC*				
Main Report					

Background & Current Situation

Further to the report shared at the April Committee, this report provides an update on progress to address the deficits raised in the recent JACIE inspection. There was, in addition, a request from the April Quality Committee meeting to share the outcome data from the Programme as part of the next update. The most recent 5 year survival data is included in this report.

Background

Following the accreditation visit on 18th and 19th September 2025, the decision was taken by JACIE to defer reaccreditation of the South Wales Blood and Marrow Transplant Programme (formal report received 12th January 2026), pending confirmation of remedial and corrective actions. We are required to respond to JACIE by 8th July 2026 with a credible, time-lined plan, when a further decision on accreditation will be made.

While clinical outcomes and laboratory practice remain strong, inspectors identified critical deficiencies in adult facilities, workforce capacity, and the absence of a strategic estates' decision for the Processing Facility.
Many of the areas of non-compliance and partial compliance identified are within the remit of the programme to correct, however there are several areas that lie outside of the gift of the Programme, requiring support and/or input variously from JCC, SBUHB, Capital Estates & Facilities, other Clinical Boards and Welsh Government.

Governance & Progress Against Actions

The SWBMT Quality Team has a comprehensive database of all 2330 standards and is systematically working through the areas of non-compliance (as a priority) and partial compliance. Each standard has an agreed action, action owner and target completion date.

A Task & Finish Group is in place, meeting 3 weekly, to monitor progress against the database and to focus on the significant, system wide actions that require input from other organisations and Clinical Boards to progress.

This action plan is included as appendix 1.

Progress Update

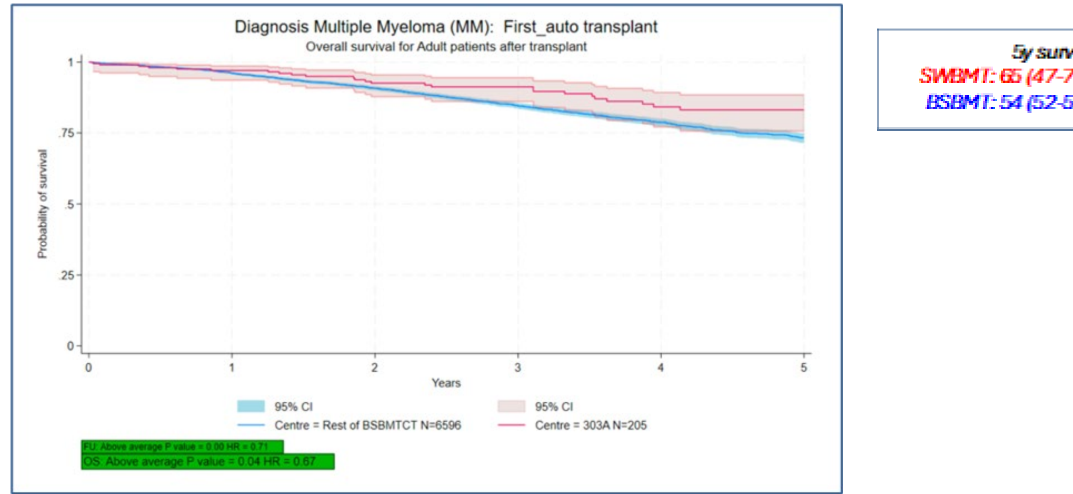
Adult Facilities (UHW)	Haem Day Centre Scheme: significant progress has been made on the groundworks, including the start of foundation and base works. The contractor's latest programme suggests handover of the new build in early January, which is later than the original November 2026 target. However, we will be able to demonstrate to JACIE that corrective action is underway, with a scheduled completion date. Due to the project's complexity and resource constraints, Gleeds Project Management and Cost Advisory Services have been appointed to manage the site and handle day-to-day management. The team are reviewing the contractor's programme and budget implications and considering the impact on completion dates.
	Inpatient/Ambulatory Scheme: The Strategic Outline Case is being finalised, aiming for submission early-mid June 2026. Welsh Government is expecting the submission and has been informed of the timeline, with an anticipated three-week turnaround for a letter of support. The SWBMT Quality team are collating the required evidence for submission to JACIE by 8th July, including the latest programme, signed-off drawings, and supporting documentation.
Paediatrics – Clinical	The key outstanding action relates to the options appraisal in light of volume of activity being lower than required for JACIE accreditation. This is due to be discussed at SLT on 4th June.
Personnel	A revenue case has been developed to incorporate the minimum workforce requirements to satisfy JACIE accreditation, focusing on the areas of non-compliance. The case has been through internal governance and scrutiny (VBRG, SLT, F&P Committee) and will be formally submitted to JCC at the end of the month for consideration of funding. The case includes a phased funding request with the minimum investment set out for in-year consideration of funding and the reminder to be considered as part of the 2027/28 IMTP.

Programme Outcome Data

Benchmarked adult autologous HSCT outcomes

Both the British Society of Blood and Marrow Transplantation and Cellular Therapy (BSBMTCT) and European Society of Blood and Marrow Transplantation (EBMT) provide benchmarked adult autologous HSCT outcomes.

The BSBMTCT 2024 report indicates that 375 autologous procedures were performed in 334 recipients between 2018 and 2022 by the SWBMT Programme. 5-year survival for the entire cohort was 78% compared with 73% for the rest of the BSBMTCT. Globally, multiple myeloma is the main indication (61.4% in 2022) for autologous HSCT. 5-year survival in the SWBMT cohort was 83% versus 73% for the rest of the BSBMTCT (Figure 1).



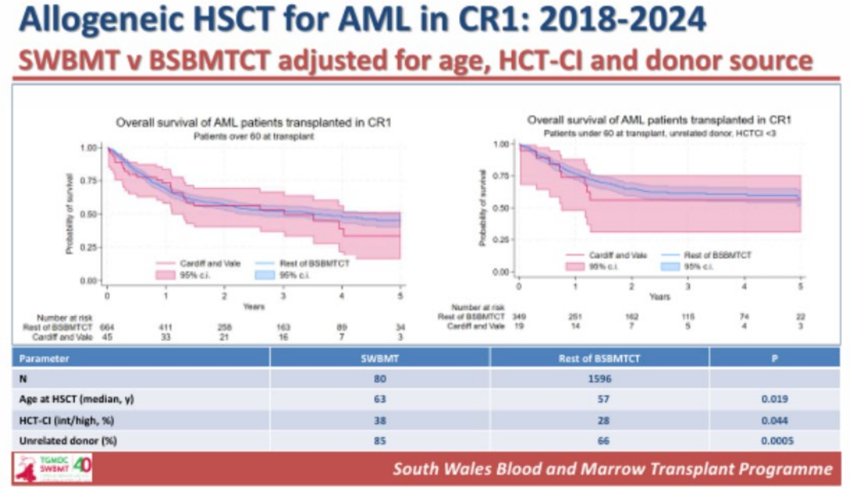
5y survival:
SWBMT: 65 (47-78)%
BSBMT: 54 (52-57)%

Figure 1: Survival following autologous HSCT for multiple myeloma. BSBMTCT 2024 annual report.

Allogeneic HSCT patient demographics

As with autologous HSCT, outcomes in allogeneic recipients have historically exceeded the UK and European averages – the key reason the SWBMT Programme was spared withdrawal of accreditation at the 2019 inspection. More recently, outcomes have become equivalent, despite Welsh patients being older and more comorbid than their UK and European counterparts.

Acute myeloid leukaemia (AML) is the single most common indication for allogeneic HSCT. At our request, the BSBMTCT undertook a comparison of outcomes of patients with AML who received an allogeneic HSCT between 2018 and 2024. The results are summarised in Figure 2.



Parameter	SWBMT	Rest of BSBMTCT	P
N	80	1596	
Age at HSCT (median, y)	63	57	0.019
HCT-CI (int/high, %)	38	28	0.044
Unrelated donor (%)	85	66	0.0005

Figure 2. Outcome following allogeneic HSCT for AML in SWBMT and BSBMTCT cohorts, 2018-2024

Note that outcomes were similar despite the SWBMT cohort being older, more comorbid and with greater use of unrelated donors – factors all associated with greater non-relapse mortality.

The importance of being able to offer allogeneic HSCT to older patients is that they bear the greatest burden of haematological disease; the median age of presentation for almost all haematological malignancies is the mid-to-late seventh decade. If these patients were not treated, most people affected by haematological malignancies would be denied potentially curative therapy. Should these patients be referred to centres in England, there is a very real possibility they might not be accepted on grounds of age or comorbidity. There is also a theoretical risk of worse outcomes given that centres in England are more accustomed to younger, fitter patients.

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

1. Updated Action Plan
2. Risk Assessment

Strategic Alignment – Shaping Our Future Wellbeing:
Please place an "X" against the strategic objective(s) this paper supports – Click the below tiles for further information.

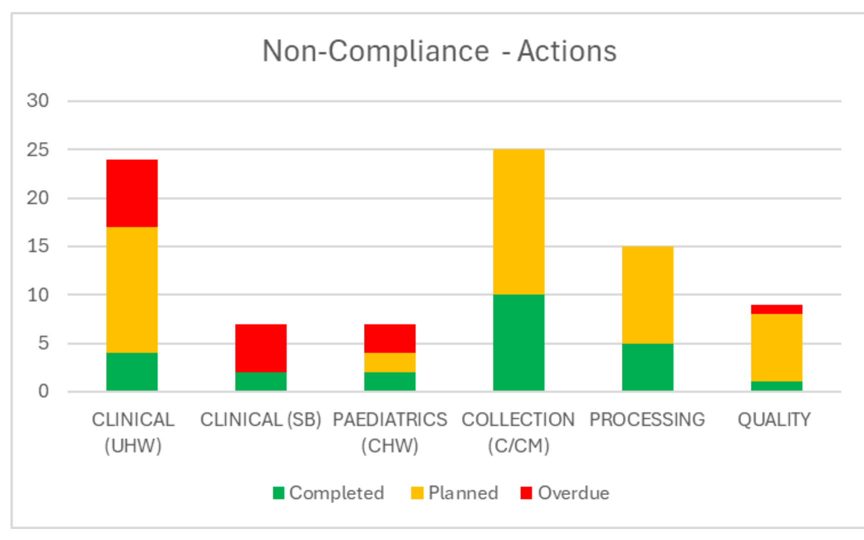
Putting People First	x	Providing Outstanding Quality	x
Delivering in the Right Places		Acting for the Future	x

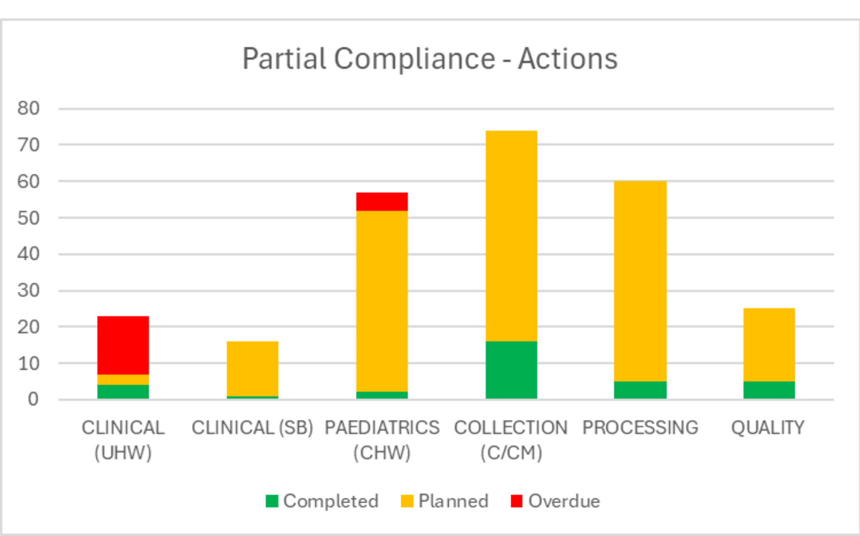
Impact Assessment
Risk: Yes
Risk Assessment attached
Safety: Yes
Risk Assessment attached
Financial: Yes
Business Case to address revenue requirements to be submitted to JCC for consideration – has been to VBRG, SLT and F&P Committee (20/5/26). *SOC to be developed for capital case.* *Financial risk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

Team	Issue	Action	Owner	Update May 2026	Risk of Action Completion by Deadline
Paediatrics - clinical	The number of autologous HSCT procedures is below JACIE requirements.	Consider options for future delivery of service in light of issue.	Children & Women Clinical Board	Options paper on agenda for SLT 4th June 2026.	
Paediatrics - collection	Number of bone marrow harvests below JACIE threshold	JACIE has suggested introducing simulation procedures or ceasing activity	Paediatric Lead/Apheresis Lead	Plan still being formulated. ND to identify relevant SOP(s), look at existing authors, and ask them to update SOP(s) to reflect new plan	
	Number of apheresis harvests insufficient to maintain competencies	Option to maintain apheresis competency by doing adult procedures			
Paediatrics - personnel	Single nurse capable of performing apheresis procedures (succession planning needed)	Consider paediatric nurses maintaining competencies on adult patients or alternatively adult nurses performing procedures on paediatric patients to improve robustness of cover			
Processing facility - personnel	Staffing levels in the processing facility are inadequate	CD&T to undertake gap analysis to address the deficits raised by JACIE	NWJCC	Revenue case progressing through internal governance. For formal submission to JCC as commissioner at end of May for consideration of phased funding.	
	Unable to provide on-call cover for LN2 storage tanks (also noted by HTA as a deficiency)				
CVUHB Adult - premises	Inadequacy of adult facilities, specifically:		Capital, estates & facilities; Clinical team	HDC extension ongoing. Delay in completion so additional support in place to review timelines and implications.	
	Haem Day Centre (adults)	Upgrade of HDC Adults in progress			
	Day Centre (TCT)	TCT-aged patients to use upgraded adult facilities until upgrade of TCT facilities			
	Inpatient facility on B4/C5 Haem	Capital scheme		SOC to be submitted mid June with supporting letter expected 2-3 weeks later.	
	Ambulatory Care				
	Outpatients				

<table>
<tr><td>SBUHB - premises</td><td>The Autologous Transplant Service needs to expand in both space and workforce to manage current demand.</td><td rowspan="7">SBUHB developing a Business Case to address deficits</td><td rowspan="7">NWJCC</td><td rowspan="7">Revenue case progressing through internal governance. For formal submission to JCC as commissioner at end of May for consideration of phased funding</td><td></td></tr>
<tr><td rowspan="6">SBUHB - personnel</td><td>The Autologous Transplant Programme requires a robust succession plan for potential Programme Directors and BMT Nursing Coordinators.</td><td rowspan="6"></td></tr>
<tr><td>The programme is heavily dependent on single CNS for smooth operation, highlighting the need for increased resilience.</td></tr>
<tr><td>Expansion of nursing roles at Singleton is needed, in line with the role expansion at Cardiff</td></tr>
<tr><td>The Nurse Educator role needs to be restructured to enable the post holder to deliver more effective transplant training to the nursing team.</td></tr>
<tr><td>The pharmacist requires dedicated time for transplant related Continuing Professional Development (CPD).</td></tr>
<tr><td>Notable differences exist between the two transplant programmes; Singleton patients do not have access to pre-habilitation or rehabilitation services, leading to inequities in patient care.</td></tr>
<tr><td rowspan="2">QA</td><td rowspan="2">Remaining non-compliant/partially compliant actions to be addressed by team</td><td>Quality team working throguh full standards spreadsheet, action owners asigned to each non or partially compliant standard</td><td rowspan="2">SWBMT Quality Team/Programme Director</td><td rowspan="2">Some delays in progressing actions due to capacity of clinical team – no significant concerns raised and expected to complete ahead of final deadline.</td><td></td></tr>
<tr><td>Vacant posts in the Quality Team to be fast tracked for recruitment</td><td></td></tr>
</table>

Non-compliant	87
Partially compliant	255
Compliant	1861
Not applicable	127





RISK ASSESSMENT FORM

Clinical Board:	Specialist Services	**Location of Risk:**	UHW
Directorate:	Haematology	**Date Form Completed:**	30/07/2025

Risk Title
Risk to Wales associated with loss of JACIE accreditation by the South Wales Blood & Marrow Transplant (SWBMT) Programme.

Description of Risk:

Cardiff & Vale University Health Board (CVUHB) is commissioned by NHS Wales Joint Commissioning Committee (NW-JCC) to provide cellular therapy services (BMT and CAR-T) for residents of South Wales, West Wales and South Powys via the South Wales Blood and Marrow Transplant (SWBMT) Programme. JACIE accreditation is standard in Europe for cellular therapies (haematopoietic stem cell transplantation (HSCT) and chimaeric antigen receptor (CAR) T-cell (CAR-T) therapy. These standards mirror the FACT standards in North America and are published as a uniform set of FACT-JACIE standards.

FACT-JACIE standards are validated with data showing that clinical outcomes in accredited centres outperform those of non-accredited centres (Gratwohl *et al.* Use of the quality management system "JACIE" and outcome after hematopoietic stem cell transplantation. *Haematologica*. 2014 May;99(5):908-15; Gratwohl *et al.* Introduction of a quality management system and outcome after hematopoietic stem-cell transplantation. J Clin Oncol. 2011 May 20;29(15):1980-6). Consequently, centres outside of Europe and North America have adopted FACT-JACIE making them truly global standards for cellular therapy programmes. Within the UK, including Wales (and therefore NW-JCC), JACIE accreditation is a prerequisite for commissioning and pharmaceutical companies will only release CAR-T products to JACIE-accredited centres.

The physical facilities of the adult Clinical Programme and Collection Facility on the CVUHB site are non-compliant with JACIE standards due to significant infrastructure and environmental deficiencies. These were noted at two prior JACIE inspections in 2013 and 2019 and there has been no material change since those inspections.

There are a number of individual concerns that are captured in detail separate risk assessments, however to summarise key themes:

Inadequate inpatient infrastructure:
- Lack of ensuite facilities for immunocompromised patients.
- Insufficient isolation rooms with adequate air handling.
- Cramped and outdated ward environments.

Day unit and outpatient deficiencies:
- Lack of triage space and inadequate isolation facilities.
- Patients exposed to nosocomial infections due to shared spaces.

Ambulatory care limitations:
- Limited chair spaces and poor layout.
- Lack of adequate isolation facilities (currently only 1 cubicle) for patients receiving high-risk therapies.

These issues violate specific JACIE standards such as:
- B2.1: Designated inpatient unit with adequate space and air quality
- B2.2: Outpatient care area with infection control and privacy

- B2.3: Ambulatory setting with minimized airborne contamination
- B2.14: Health and safety risks to employees, recipients, donors, visitors and volunteers
- C2.1.1 to C2.3: Apheresis collection areas with proper environmental controls

Should JACIE accreditation be withdrawn at the upcoming JACIE reinspection in September 2025, delivery of CAR-T would not be possible within Wales due to the withdrawal of CAR-T products by pharma and BMT would have to be decommissioned given current commissioning policy. This would have a severe adverse impact on haematological cancer care across the SWBMT Programme catchment area, which accounts for ~80% of the Welsh population. The significance of this is underlined by the fact that for many patients with haematological malignant and non-malignant conditions (such as bone marrow failure syndromes), BMT and CAR-T represent the only means of cure. Patients in Wales would therefore be consigned to suboptimal clinical outcomes, including shortened survival, for conditions that are potentially curable.

Additionally, the SWBMT Programme is licensed by the Human Tissue Authority (HTA) for activities pursuant to the Human Tissue Act 2004 and the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended) [HTA Human Application Licence 11094]. Closure of the SWBMT Programme would invalidate the need for an HTA licence leading to the need for an alternative storage solution for the thousands of cellular therapy products currently cryopreserved within the SWBMT Processing Facility.

Surrender of the HTA licence and the absence of JACIE-accredited facilities would have wider clinical impact, involving all current clinical trials in acute myeloid leukaemia, acute lymphoblastic leukaemia, non-Hodgkin lymphoma, Hodgkin lymphoma, multiple myeloma and bone marrow failure syndromes, since the SWBMT Programme would not be able to support those trials as is currently the case.
Putting research activity into context:

- Over the 5-year period January 2020 to December 2024, (which included the COVID-19 pandemic), the SWBMT Programme participated in over 50 trials, recruiting 587 participants.
- In November 2020, again at the height of the COVID-19 pandemic, the Wales Cellular Therapy Consortium was formed to bring together researchers across a wide range of disciplines to benefit from the excellent clinical database and virtually complete follow-up. Grant income won with research partners between 2021 and 2024 totalled £3.4 million.
- Commercial trial income for financial year 2024/25 alone amounted to £214,287.15.

Via its HTA licence, the SWBMT Programme currently supports several non-haematological cancer and non-cancer trials, particularly involving advanced therapies. Without an applicable Human Application HTA Licence, trials currently ongoing, in an advanced stage of set-up or under consideration would cease, denying Welsh patients access to ground-breaking therapies currently unavailable on the NHS with loss of the opportunity to benefit from cost avoidance given that these therapies are provided free-of-charge within the clinical trial. Examples include, but are not limited to:

- CARTITUDE-6: A phase III trial of CAR-T v standard-of-care (SOC) for patients with newly diagnosed multiple myeloma. The SOC arm includes therapies not currently available on the NHS. The SWBMT Programme was the first UK centre to open this trial.
- TILVANCE 301: A phase III trial of tumour infiltrating lymphocytes (TILs) with pembrolizumab v pembrolizumab alone for the first line treatment of patients with metastatic malignant melanoma. This trial is in an advanced state of set-up.
- AMELIE: A phase I/IIb trial of autologous skeletal muscle-derived cell microcarrier combination for the treatment of faecal incontinence in women with obstetric anal sphincter injury. This trial is in an advanced state of set-up with the site initiation visit scheduled for September 2025.
- An autologous CAR-Treg trial for patients at risk of developing (or early phase) type 1 diabetes mellitus. Expression of interest declared by Cardiff on behalf of the Type 1 Diabetes UK Immunotherapy Consortium, with the aim of being the main recruitment centre for the UK. The clinical, sociological and financial impact of preventing type 1 diabetes mellitus (and insulin usage) in a primarily young population needs no elucidation.

Score Risk **without** Current Controls (Initial Risk Score)							
Consequence	5	X	Likelihood	5	=	Risk Rating	25

Controls in Place:
Haematology Directorate/Specialist Services Clinical Board
1. **Established Quality Management System (QMS):** Regular audits, SOPs, and continuous improvement processes aligned with JACIE standards.
2. **Multidisciplinary Governance:** Oversight by clinical, laboratory, and quality leads.
3. **Training and Competency Frameworks:** Regular staff training and competency assessments.
4. **Participation in BSBMTCT and EBMT Registries:** Enables benchmarking and outcome tracking.
5. **Clinical Excellence:** Strong clinical outcomes and experienced multidisciplinary teams
6. **Ambulatory Care Model:** Reduces inpatient pressure and improves flexibility.
7. **Weekly Planning Meetings:** Intensive triaging to manage bed capacity and patient risk.
8. **Unscheduled care triage beds:** Separate bedded area to triage and screen unscheduled care admissions prior to admission to haematology ward, reducing risk of nosocomial infection.
9. **Dedicated toilet/shower facilities:** communal facilities designated for use by specific patients to reduce risk of nosocomial infection.
Cardiff & Vale UHB
1. Development of Business Case for new clinical facility for SWBMT Programme
2. Continued engagement with Welsh Government regarding prioritisation of capital allocation for new facility
3. Agreement from WG Capital and Estates team to attend JACIE accreditation visit to provide assurance regarding prioritisation
4. Agreement to provide temporary accommodation to extend the Haematology Day Unit footprint

Score Risk **with** Current Controls (Current Risk Score)							
Consequence	5	X	Likelihood	4	=	Initial Risk Rating	20

Consequence	Likelihood 1 Rare	 2 Unlikely	 3 Possible	 4 Likely	 5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

	1-3	Low risk
	4-6	Moderate risk
	8-12	High risk
	15-25	Extreme risk

Gaps in Controls:
1. **Infrastructure Deficiencies – inpatients:** a. Inadequate isolation facilities and air handling provision b. Lack of ensuite facilities for transplant patients resulting in poor patient experience and increasing risk of nosocomial infections from shared communal areas/facilities c. Overcrowded and outdated ward environment with poor physical fabric
2. **Infrastructure Deficiencies – day care:** a. Inadequate isolation and triage/screening facilities and air handling provision b. Overcrowding and lack of appropriate waiting area

c. Insufficient space for volume of patients
3. **Infrastructure Deficiencies – outpatients:** a. Inadequate isolation facilities and air handling provision b. Overcrowding and lack of appropriate waiting area c. Insufficient space for volume of patients
4. No approved capital scheme to rectify the infrastructure deficiencies
5. Limited mitigation within current clinical facilities at UHW

Assurances:
1. **Previous JACIE Accreditation:** Demonstrates historical compliance.
2. **HTA Licensing:** In place since 2007.
3. **Internal Quality Reports:** Regular reporting to governance boards.
4. **Clinical Outcomes:** Among the best in the UK despite infrastructure issues.
5. **Patient Outcome Monitoring:** Through BSBMTCT, EBMT and internal KPIs.
6. **External Peer Reviews:** Participation in national and international benchmarking.
7. **Prioritisation:** Capital scheme prioritised by both the Health Board and Welsh Government
8. **Capital Scheme:** Strategic outline case submitted to Welsh Government in 2023 – ongoing dialogue with WG who are supportive and have indicated prioritisation of capital scheme.

Gaps in Assurance:
1. **No material improvements since previous inspections and feedback**
2. **No Contingency Plan:** For service continuity if accreditation is lost.
3. **Limited Independent Oversight:** Lack of external validation between accreditation cycles.

Actions Required to reduce risk rating:	**Action Lead**	**Target Completion Date**
Secure agreement of Business Case route for capital scheme	Welsh Government/Director Capital, Estates & Facilities	Q2 2025/26
Secure funding for capital scheme	Welsh Government/Director Capital, Estates & Facilities	Q2 2026/27
Complete infrastructure updates to JACIE standards	Director Capital, Estates & Facilities	Q2 2027/28
Implement interim infection control mitigations – e.g. reduce day centre overcrowding	Director Capital, Estates & Facilities	Q2 2025/26

Notepad:

Considering all of the information you have on the controls and assurances how would you rate the risk when the actions are completed (Target Risk Score):

Consequence	**5**	**X**	**Likelihood**	**2**	**=**	**Target Risk Rating**	**10**

Main Risk Type: ***please tick one only***

Clinical Care/Quality	Communication/PR	Compliance with Standards	Corporate Governance	Estates

Financial	Health & Safety	Information Governance	Infection Control	Legal
Safeguarding	Security	Social Care	Strategic	*Other – please specify:*

Signature of Assessor
Date of Assessment
Risk Owner
Signature of Clinical Board Director
Date

Appendix 1 – JACIE Standards

JACIE Standard	Requirement	Unmet Issue
B2.1	Designated inpatient unit with appropriate location, space, and design to minimize airborne microbial contamination	Inadequate isolation rooms, lack of ensuite facilities, outdated infrastructure
B2.2	Designated outpatient care area with infection control, isolation, and privacy	Cramped outpatient clinics, no triage or isolation, exposure to nosocomial infections
B2.3	Ambulatory care area with appropriate space and design to minimize airborne contamination	Poor layout, limited isolation, inadequate air handling
B2.14	Minimize risks to health and safety of employees, recipients, donors, visitors, and volunteers	Exposure to infection, lack of hygiene facilities, overcrowding
C2.1.1	Collection area with adequate space and design to minimize airborne microbial contamination	Apheresis area lacks proper isolation and air handling
C2.1.2	Defined areas to prevent mix-ups, contamination, or cross-contamination	Shared spaces for donor apheresis (progenitor cell, MNC and MNC for CAR-T

JACIE Standard	Requirement	Unmet Issue
		manufacture harvesting) and therapeutic apheresis
C2.1.4	Suitable space for confidential donor examination and evaluation	No dedicated private space for donor evaluation
C2.2	Adequate lighting, ventilation, and access to sinks and toilets	Limited facilities in day unit and ambulatory care
C2.3	Controlled environmental conditions to protect safety and comfort	Poor infection control and patient comfort in shared areas

<table>
<tr><td>Report Title:</td><td colspan="3">HIW Inspection in Short Stay Surgical Unit (SSSU)</td><td>Agenda Item No:</td><td>3.4.4</td></tr>
<tr><td rowspan="2">Meeting:</td><td rowspan="2">Quality Committee</td><td>Public</td><td>X</td><td rowspan="2">Meeting Date:</td><td rowspan="2">02.06.2026</td></tr>
<tr><td>Private</td><td></td></tr>
<tr><td>Lead Executive Title:</td><td colspan="5">Executive Nurse Director</td></tr>
<tr><td>Report Author/s Title:</td><td colspan="5">Deputy Head of Quality and Patient Safety</td></tr>
</table>

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).*

HIW inspection identified significant patient safety, environmental, medicines management and managerial concerns within SSSU, including unsafe medication storage, unsecured records, IPC risks and staff experience issues. Immediate risks were addressed during and shortly after inspection; however, ongoing risks relate to embedding cultural change, workforce stability, and ensuring consistency of safe practices.

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

A comprehensive improvement programme is in place, with executive oversight and structured governance. Progress continues across patient safety, workforce, culture, and operational delivery, including implementation of improvement plans, workforce interventions, and organisation-wide learning (e.g. medication safety review). Continued monitoring, staff engagement, and system-wide actions will be required to ensure sustainability and consistency.

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

Immediate patient safety risks identified by HIW have been mitigated, with all urgent actions completed and a robust improvement programme established. There is clear evidence of strengthened governance, improved compliance, enhanced safety systems, and cultural development.

The People and Culture review is currently in the discovery phase, with staff focus group sessions completed to inform the diagnostic process. To ensure all staff voices are captured, individuals who did not participate in group sessions are being proactively offered confidential one to one meetings.

Ongoing monitoring, executive oversight, and defined review points support sustained improvement and organisational learning.

<table>
<tr><td colspan="6">Board/Committee Response Required (please select only one)</td></tr>
<tr><td>Assurance</td><td>X</td><td>Approval</td><td></td><td>Information/Noting</td><td></td></tr>
<tr><td colspan="6">Recommendations
Recommendations should be clear, actionable, and aligned to the AAA summary above.</td></tr>
<tr><td colspan="6"></td></tr>
</table>

The Committee is asked to:

A. Take **assurance** from the actions completed to address immediate patient safety risks and the progress made against the HIW improvement plan, noting that all actions are either completed or on track within agreed timescales.
B. **Note** that the ongoing People and Culture review.

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

Background

Healthcare Inspectorate Wales (HIW) undertook an inspection of the Short Stay Surgical Unit on 13th and 14th January 2026. The report was published by HIW on 16th April 2026. The full report can be accessed here: 20260416UHWEN.pdf

The inspection identified significant concerns relating to patient safety, environment, medicines management, governance, and staff experience; however, immediate risks were addressed promptly, and a comprehensive improvement programme is now in place. The Board is asked to take assurance that robust actions have been implemented, with sustained improvement and cultural change underway.

This report provides an overview of the actions taken to address the findings and recommendations from HIW and the organisational response to staff feedback, progress against the full improvement plan, and the wider organisational learning identified. Overall, substantial progress has been delivered at pace, with strengthened governance, improved oversight, and clear evidence of improvement. Work continues to ensure that these changes are embedded and sustained.

Immediate safety actions taken

The inspection identified a number of immediate patient safety risks, particularly in relation to medicines management, information governance, infection prevention and control, and environmental safety. Concerns included unsafe medication storage, the presence of expired medications, unsecured patient records, environmental cleanliness issues, and risks associated with estates and equipment decontamination.

In response, a series of immediate actions were implemented.

- Medication safety was strengthened through the removal of expired stock, improved storage processes, and the allocation of a dedicated pharmacy support. Medicines storage arrangements were enhanced through restoring controlled access to medication rooms.
- The secure storage of patient records was strengthened through the procurement of lockable trolleys and the repurposing of rooms to increase lockable notes storage facilities.
- Environmental risks were addressed through a full deep clean of the unit, the replacement of window coverings and strengthened escalation processes for cleaning, and enhanced audit and monitoring arrangements.

- Equipment decontamination was strengthened by reinforcing the correct techniques and processes with all staff, the use of visual prompts for staff, and strengthened audit oversight.

These actions ensured that immediate risks were mitigated and that improvements were evident during the inspection period. All actions identified within the immediate improvement plan have now been completed.

Organisational response to staff feedback

HIW undertook as staff survey as part of their inspection process. The results of this survey raised concerns around leadership, culture and staff wellbeing.

An immediate review of rota practices and delegation was undertaken by the Corporate HealthRoster Team, which identified no immediate concerns in rostering practices. This review included interrogation of shift requests compared with declined requests, as well as a review of staff that were moved to work in other areas. The Health Board has also initiated a six-month retrospective rota analysis examining allocation patterns, weekend working, distribution across roles and bands and delegation equity.

In response to these concerns a comprehensive Culture, Leadership and Education Improvement Plan was established to reinforce and embed psychological safety, workforce stability, and organisational culture as fundamental components of patient safety and quality of care. The programme is led by the People and Culture Team in partnership with the Surgery Clinical Board and governed through established clinical board structures, ensuring clear accountability and oversight.

The Culture Leadership and Education programme commenced with a diagnostic phase that includes engagement with staff through surveys and listening sessions, alongside analysis of workforce data such as turnover, sickness, training compliance, and rota patterns. The review considers core domains including leadership, psychological safety, equity and fairness, staffing sustainability, and operational support, ensuring a comprehensive understanding of both underlying causes and presenting issues. To date, staff focus group sessions have been completed, providing valuable insight into lived experience. To ensure that all staff voices are heard, individuals who did not participate in group sessions are being offered confidential one-to-one meetings. This approach supports inclusivity and ensures a full and balanced understanding of staff experience.

A review of Value Based Appraisal compliance demonstrated compliance of 70% with ten appraisals overdue at the time. A plan was put in place to address this backlog with the relevant staff and compliance is now 94.29%. A review of arrangements to support staff returning to work from periods of absence, demonstrated that Keeping In Touch days were routinely used for staff returning from parental leave and for staff returning from long term sickness, there was evidence of agreed phased returns to support them through this transition and assurance was provided to HIW.

Alongside diagnostic work, immediate actions have been taken to improve leadership visibility, reinforce expected behaviours, strengthen mechanisms for speaking up, and address concerns relating to fairness, training access, and workforce sustainability. A zero-tolerance approach to bullying and discrimination has been reinforced, with clear processes for escalation and investigation. Improvements have also been made to operational support, including pharmacy provision, housekeeping, and escalation processes.

A formal monitoring framework has been established to ensure that improvements are sustained. This includes regular review points, repeat staff surveys, workforce metrics monitoring, and reporting through clinical board and executive governance structures.

Progress Against Full Improvement Plan

Following the development of the full inspection report, a comprehensive improvement plan was developed and implemented in response to the HIW findings. All actions are either completed or progressing within agreed timescales, with clear oversight arrangements in place. Improvements have been demonstrated across patient safety, clinical care, governance, patient experience, and workforce domains. The improvement plan updated to May 2026 is included in Appendix 1.

There is evidence of strengthened clinical audit processes, improved compliance with training requirements, and enhanced monitoring of key safety indicators such as infection prevention, documentation standards, and risk assessments. Patient experience has been improved through enhanced information provision, environmental improvements, and the introduction of more accessible and supportive resources.

Strengthened governance and information security arrangements have been maintained, with full compliance now achieved in the secure storage of patient information and robust monitoring processes in place. Workforce improvements include leadership development, increased engagement, and targeted interventions to improve culture, staffing sustainability, and staff experience. Operational improvements have also been made to staffing models, patient flow, and service delivery processes.

Organisational-wide learning identified

The inspection findings have highlighted opportunities for wider organisational learning beyond SSSU. A number of themes, including variation in patient information, medication safety, and environmental standards, have been identified as relevant across the Health Board.

In response, work is underway to standardise health promotion information across clinical areas and to improve dementia-friendly environments in line with best practice guidance. A Health Board-wide medication storage audit has also been undertaken, identifying areas for improvement in storage, security, and compliance. This is being addressed through a coordinated programme of standardisation, training, and monitoring.

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

- **Appendix 1 – HIW improvement plan updated to May 2026**

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
A medication storage risk assessment was undertaken to support mitigation in relation to the limited preparation area.
Safety*:* Yes
There were a number findings that impacted patient safety and quality. These have been addressed in the improvement plan and are subject to ongoing monitoring.
Financial*:* No

***Workforce**: Yes*
A comprehensive Culture, Leadership and Education Improvement programme has been commenced in response to the results of the staff survey.
Legal*:* No
HIW inspections are in the public domain.
Socio Economic*:* No - *https://www.gov.wales/socio-economic-duty-guidance*
Welsh Language*:* No

Report Title: *(needs to match agenda)*	Additional Learning Needs (ALN) Internal Audit report update		Agenda Item No:		4.1.1
Meeting:	Quality Committee	Public	x	Meeting Date:	02/06/2026
		Private			
Lead Executive Title:	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development				
Report Author/s Title:	Designated Education Clinical Lead Officer				

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 progress made to date demonstrates a trajectory of improvement, with multiple actions achieved or progressing that collectively enhance governance, workforce capability, partnership working, and quality assurance—providing the Committee with reasonable to substantial assurance across most domains.

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

Recommendations

The Committee is asked to:

1. **Approve** progression to finalisation and implementation of the ALN Governance Policy
2. **Endorse** strengthened training and workforce oversight arrangements
3. **Support** continued development of multi-agency working arrangements
4. **Strengthen** statutory compliance monitoring
5. **Monitor** governance effectiveness and engagement

So that the progress made translates into sustained, measurable improvements in governance, workforce capability, partnership working, and statutory compliance.

Governance Route ***(please list all other Committee/Groups this report has been to)***	
Where *it's been:*	Children & Women Clinical Board Quality & Safety Meeting
When *it went:*	26/05/2026
What *decision was made:*	Noted

Main Report

Background & Current Situation

Background:

Internal Audit reviewed the implementation of the Additional Learning Needs system in line with the 2025/26 Internal Audit Plan for the Cardiff and Vale University Health Board ('the Health Board'). The purpose of the audit was to provide assurance on the arrangements in place to ensure compliance with and adherence to the Additional Learning Needs and Education Tribunal (Wales) Act, Regulations made under the Act and the statutory ALN Code (the ALN system or legal framework).

Internal Audit concluded reasonable assurance on this area. The significant matters requiring management attention included:
· The Health Board currently lacks an overarching ALN Governance Policy that clearly defines the overall governance arrangements and establishes organisational accountability for compliance with and adherence to the ALNET Act, Regulations and the ALN Code.
· Identification of ALN training needs and maintenance of attendance records for ALN training sessions have not occurred, resulting in an inability to assess training session participation levels.
· There is uncertainty about ALN Champions' training, development, and role expectations. Survey responses also revealed ongoing concerns and recurring questions about their responsibilities.
· The Health Board attendance levels at the Regional Health and Education ALNET Steering Group (RASG) is low, resulting in one meeting not being quorate.
· The Health Board lacks an overarching strategic ALN implementation document, nor has it developed a joint work plan between health and education partners.
· The Health Board has not been able to determine future ALN demand since the implementation of the system is still evolving and both legal and operational factors keep changing.
· The use and interpretation of weekly nudge reports vary, and there is no clear evidence to support that outstanding requests are being thoroughly scrutinised and challenged appropriately consistently by all services.
· There is inconsistent engagement with the Statutory Duty Monitoring (SDM) process across the various services.
· The ALN KPI dashboard trial in 2024 was paused due to uncertainty about Health ALN KPIs across Wales. The PARIS module is still in development, with the DECLO Team tracking changes since February, but limited access to PARIS development time slows progress.
· Attendance at the ALN Implementation Operational Group (ALNIG) meetings has been low; ten services, accounting for 45%, were absent from all of the sessions reviewed.

Following the receipt of the Internal Audit report, an action plan was agreed spanning the period 01/01/2026 – 31/12/2026.

Current Situation:

The report below describes the progress being made to date for each of the relevant objectives:

Objective 1: Sufficient progress is being made to implement the ALN Act through developing strategies, policies and procedures, and delivery plans

Assurance: Reasonable

Agreed Action:	Deadline: 31/10/2026 Progress Update to Date:
A documented governance control procedure will be developed and approved. The document will: 1.1 Clearly define governance structures, roles, and responsibilities for ALN compliance. 1.2 Standardise reporting requirements and escalation procedures for ALN-related data across all relevant teams. 1.3 Be communicated to all key individuals involved in ALN processes.	 1.1 Achieved – described in draft ALN Governance Policy, currently out for wider consultation. 1.2 Achieved – described in draft ALN Governance Policy, currently out for wider consultation. 1.3 Achieved – draft ALN Governance Policy circulated to all key individuals as part of the re-iterative consultation process

1.4 Include a schedule for regular review and update, with review dates recorded. Expected Evidence of Implementation: 1. ALN Governance Policy	1.4 Achieved – described in draft ALN Governance Policy, currently out for wider consultation.

Objective 2: There is sufficient training and engagement with staff
Assurance: Reasonable

Agreed Action:	Deadline: 31/12/2026 & 31/10/2026 Progress Update to Date:
2.1 For DECLO led ALN training, attendance logs will be kept and shared with the relevant ALN Champions. 2.2 Heads of Service/Department/Medical Specialty supported by their ALN Champions will establish via the annual VBA cycle, the ALN related training needs of their staff, which will be included in the 'Service-wide' training needs registers. This training will include accessing national training videos, internal supervision and training as well as DECLO led training. 2.3 ALN related training needs will be shared with the DECLO to help inform the focus and content of future DECLO led training. 2.4 Heads of Service/Department/Medical Specialty supported by their ALN Champions will monitor the attendance of and completion by their staff of ALN training, thus ensuring that all staff are ALN competent as relevant to their role. Expected Evidence of Implementation: 1. Relevant Services/Departments/Medical Specialties informed by the VBA process, will as part of their service-wide training needs analysis, identify ALN related training requirements and liaise with the DECLO to agree the development as well as delivery of the required training. 2. Services will monitor the attendance by their staff at the VBA identified training, supported by the DECLO, when relevant. 2.5 ALN Champion roles, responsibilities, and expectations will be clearly defined and communicated to prevent gaps in accountability or process ownership.	2.1 Achieved – Attendance log in situ and accessible via ALNOG TEAMS channel, roles and responsibilities reflected in draft ALN Governance Policy. 2.2 Achieved – Roles and responsibilities reflected in draft ALN Governance Policy; draft HB ALN Continuing Professional Training Offer developed; ALNET Act HB Sharepoint site updated. 2.3 Achieved – Described in draft ALN Governance Policy; included as standard agenda item ALNOG. 2.4 Achieved – Described in draft ALN Governance Policy; draft HB ALN continuing Professional Training Offer developed, ALNET Act HB Sharepoint site updated. 2.5 Achieved – ALN Champion roles, responsibilities and expectation paper

Expected Evidence of Implementation: 1. Description of the ALN Champion role, responsibilities and expectations to be included in the ALN governance control policy.	consulted on and integrated in draft ALN Governance Policy.

Objective 3: Arrangements are in place to ensure effective multi-agency working between the health board, local authorities, and other partner organisations who cohesively engage and communicate with the public and service users

Assurance: Reasonable

Agreed Action:	Deadline: 31/03/2026 & 31/12/2026 Progress Update to Date:
3.1 Automated reminders and calendar invitations will be sent to all individuals required within the Health Board to attend the RASG meetings. These communications will highlight the significance of their participation (including proposals of agenda items in advance of meetings), both in terms of ensuring the meeting's relevance, validity and supporting effective decision-making processes. 3.2 In addition, a review of the current arrangements for alternate representation will be undertaken to verify their suitability as this may help with the development of the joint overarching strategic vision. As an example, it has been noted that the Senior Lead for Therapies stands in for the Clinical Director for Allied Health Professionals (AHP), but this role only covers a specific segment of the Allied Healthcare Professionals group. The adequacy of such alternative representation will therefore be assessed to ensure comprehensive and appropriate coverage. Expected Evidence of Implementation: 1. Review of ToR, including principle duties, operational responsibilities and membership. 3.3 As per ALN legislative review recommendation, one of the WG recommendations is for RPBs to help promote a whole-system-approach to improve multiagency, integrated population planning, accountability and delivery for school aged children and young people with Additional Learning Needs.	3.1 Achieved – Automated reminders with supporting email message in situ. 3.2 Partially achieved/In progress – RASG Meeting Evaluation Survey to be circulated to membership. As an interim measure the ToR has been reviewed so that the joint work plan (2026-2027) could be developed and finalised. 3.3 Achieved – ALN included as a Priority Area in the draft Starting Well Delivery Plan 2026-2027, Leads Cardiff LA Director of Education and DECLO.

3.4 In addition, as in line with the RASG ToR, a joint work plan will be developed with clear shared ownership between health and education partners, ensuring responsibilities do not fall disproportionately on the DECLO. <u>Expected Evidence of Implementation:</u> 1. The RPB engages in strategic planning for children with ALN. 2. The RASG workplan will be in place, informing the focus of future meetings.	3.4 Achieved – Draft work plan due for approval at RASG meeting of 02/07/2026.

Objective 4: There is an efficient and consistent system for recording and managing ALN requests, referrals, and notifications along with monitoring outcomes

Assurance: Reasonable

Agreed Action:	Deadline:31/12/2026 Progress Update to Date:
4.1 Services will conduct a formal evaluation of future ALN demand and required resources. <u>Expected Evidence of Implementation:</u> 1. Future ALN Demand and Capacity Analysis has been completed by all relevant services/departments/medical specialties.	4.1 In progress – Initial meeting held between Cardiff LA senior officers & HB senior Officers re planned expansion of ALN provision with agreement for ongoing dialogue.

Objective 5: There are robust quality assurance measures in place to demonstrate compliance with the ALN Act

Assurance: Limited

Agreed Action:	Deadline: 31/03/2026, 31/03/2026 & 30/06/2026 Progress Update to Date:
5.1 As part of the ALN Governance Policy, a process map with supporting narrative will be created to standardise how services monitor and review nudge reports and then take action to address outstanding requests and referrals, ensuring consistency and clear understanding across all teams. 5.2 Current recipients of the report to confirm continued receipt of the report or suggest an alternative as well as suggest alternate in case of non-availability, for their service, so that the distribution list is up-to-date and relevant. 5.3 In addition, the confirmed named individuals on the distribution list will ensure that they understand the	5.1 Achieved – Process map developed, currently out for consultation following which it will be incorporated in the ALN Governance Policy. 5.2 Achieved – Weekly nudge report distribution list confirmed and communicated with PARIS Support Team. 5.3 Achieved – Updated email message setting out expectations accompanies weekly nudge report.

expectations linked with the receipt of the weekly nudge report and take appropriate action as relevant. Expected Evidence of Implementation: 1. Reduction in the number of statutory duties breaches for s65s and s20s. 2. Reduction in the number of non-statutory s65s not responded to within 6 weeks. 3. Elimination of statutory s65s and s20s which are closed as not responded to at day 226 post receipt. 5.4 As part of the ALN Governance Policy a process map with supporting narrative will be created to standardise how Services, through their ALN Champion, monitor their ALN compliance and engage with the SDM meetings, ensuring consistency, clear understanding and effective engagement across all teams, as part of the governance control document. 5.5 In addition, the ALN Champions will ensure that they understand the expectations linked with SDM procedure and take appropriate action as relevant. Expected Evidence of Implementation: 1. Timely and robustly completion of the SDM Form. 2. Regular attendance at the SDM meetings. 3. Reduction in the number of statutory duties breaches for s65s and s20s. 4. Reduction in the number of non-statutory s65s not responded to within 6 weeks 5. Elimination of statutory s65s and s20s which are closed as not responded to at day 226 post receipt. 5.6 The ALN dashboard will be finalised to capture all key metrics (requests received, completed, outstanding, categorised by type and reporting period) and relevant staff will receive training on the ALN dashboard as relevant to their role and ALN related responsibilities. 5.7 The ALN dashboard will be discussed at service/department/medical specialty governance meetings, for monitoring	5.4 Partially achieved/In progress – Updating of PARIS management module. 5.5 Achieved - Described in draft ALN Governance Policy. 5.6 Partially Achieved/In progress – Completed ALN KPI Impact Assessment; participate in National ALN KPI Reporting Trial (DHCW/NHSP&I) 5.7 Partially achieved/In progress – Described in draft ALN Governance Policy

and reporting purposes and breaches will be investigated and followed up. 5.8 Services/Departments/Medical Specialties will report their ALN compliance ultimately to the Board, via the established governance routes, in order to provide the necessary assurance. 5.9 As part of the ALN Governance Policy a process map with supporting narrative will be created to standardise how Services ensure consistent use and escalation of unresolved cases, with progress reported within the service groups. 5.10 Regular 'PARIS development time requires to be assigned to 1) finalise the development of the ALN KPI dashboard 2) address the outstanding issues on the tracker 3) be responsive to any future PARIS ALN issues. Expected Evidence of Implementation: 1. Monthly reporting of ALN compliance via dashboard	5.8 Partially achieved/In progress – Described in draft ALN Governance Policy 5.9 In progress – 5.10 In progress -

Objective 6: There are appropriate mechanisms for dealing with complaints, disputes, and appeals to the Tribunal
Assurance: Substantial

Objective 7: Appropriate governance framework is in place to provide oversight of compliance with the ALN Act including that the statutory roles and responsibilities of the Designated Educational Clinical Lead Officer (DECLO) are being met
Assurance: Reasonable

Agreed Action:	Deadline: 31/03/2026 Progress Update to Date:
7.1 Review the ToR of ALNIG, particularly its membership and differentiate membership in terms of relevance to the service/department/medical specialty.	7.1 Achieved – ToR reviewed and updated to be formally approved at next ALNOG meeting on 24/06/2026.
7.2 Senior leaders will reiterate the importance of attending the ALNIG meeting, ensuring all services particularly ALN Champions understand their obligations.	7.2 Partially achieved/In progress - Described in draft ALN Governance Policy
7.3 Senior leaders will directly contact non-attending services to understand barriers (e.g., workload, lack of clarity, competing priorities) and offer support where necessary.	7.3 Partially achieved/In progress – Described in draft ALN Governance Policy
7.4 The DECLO will share an attendance register with senior leaders who will address ongoing attendance issues	7.4 Achieved – attendance register in situ

related to persistent non-attendance, clearly communicating attendance expectations, and outlining the consequences of repeated absences. <u>Expected Evidence of Implementation:</u> 1. Improved attendance in terms of number of services represented, their regularity and duration of attendance.	

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

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
Failure to comply with the ALN Act statutory duties exposes the Health Board to legal challenge, patient harm, financial loss, reputational damage, and system-wide failure in integrated care, ultimately impacting the expectations, experiences and outcomes of children and young people with additional learning needs.
Safety: Please select
Failure to comply with the ALN Act statutory duties could result in poorly coordinated care between Health, Education Settings, and Local Authorities ultimately impacting the expectations, experiences and outcomes of children and young people with additional learning needs.
Financial: Yes
The ALN Act was designed on the basis of system efficiencies offsetting additional demand, however based upon implementation experience to date, statutory duties compliance has led to increased activity, workforce pressure and coordination costs.
Workforce: Yes
Workforce capacity is insufficient to sustainably meet the statutory duties of the ALN Act, potentially resulting in staff burnout, reduced productivity, and inability to consistently deliver timely and effective care.
Legal: Yes
Failure to comply with the statutory duties could lead to appeals being lodged with Education Tribunal for Wales, complaints escalating to the Public Services Ombudsman for Wales (PSOW), or a judicial review being launched against the Health Board. This may result in Court orders, mandated changes in practice, reputational damage, and have potential cost implications.
Reputational: Yes
The Health Board is a key partner in delivering ALN reforms, and therefore failure to comply with statutory duties could lead to future negative inspection findings, future negative findings of formal reviews and public criticism from families and advocacy groups. This may undermine trust with Local Authorities, Education Settings and Children & Young People and their Families, leading to loss of confidence and credibility across the system.
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
No applicable
Equality & Health: No
Not applicable
Decarbonisation: No
Not applicable

Welsh Language: Yes
Compliance with the statutory duties strengthens the HB's compliance with Welsh Language duties by embedding language preference, bilingual provision, and enforceable rights within statutory care planning processes (IDPs).

Report Title:	Clinical Audit Forward Plan 2026/2027		Agenda Item No:	4.1.2
Meeting:	Quality Committee	Public: x Private:	Meeting Date:	02.06.2026
Lead Executive Title:	Executive Medical Director			
Report Author/s Title:	Deputy Head of 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).*

Resourcing of National Clinical Audits remains variable across the UHB which has led to sub optimal case ascertainment and data completeness in some cases.

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

The UHB Clinical Audit Policy and Strategy will be refreshed in 2026. The governance and oversight of clinical audits will be strengthened and aligned to the UHB review of clinical governance reporting.

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

The Committee should note the breadth of the planned clinical audits and note that the audit plan is dynamic and will be added to throughout the year.

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

Assurance		Approval		Information/Noting	x

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

The Committee are asked to:

A. **Note** the breadth of the clinical audit forward plan and participation in the national clinical audit and outcome review plan.

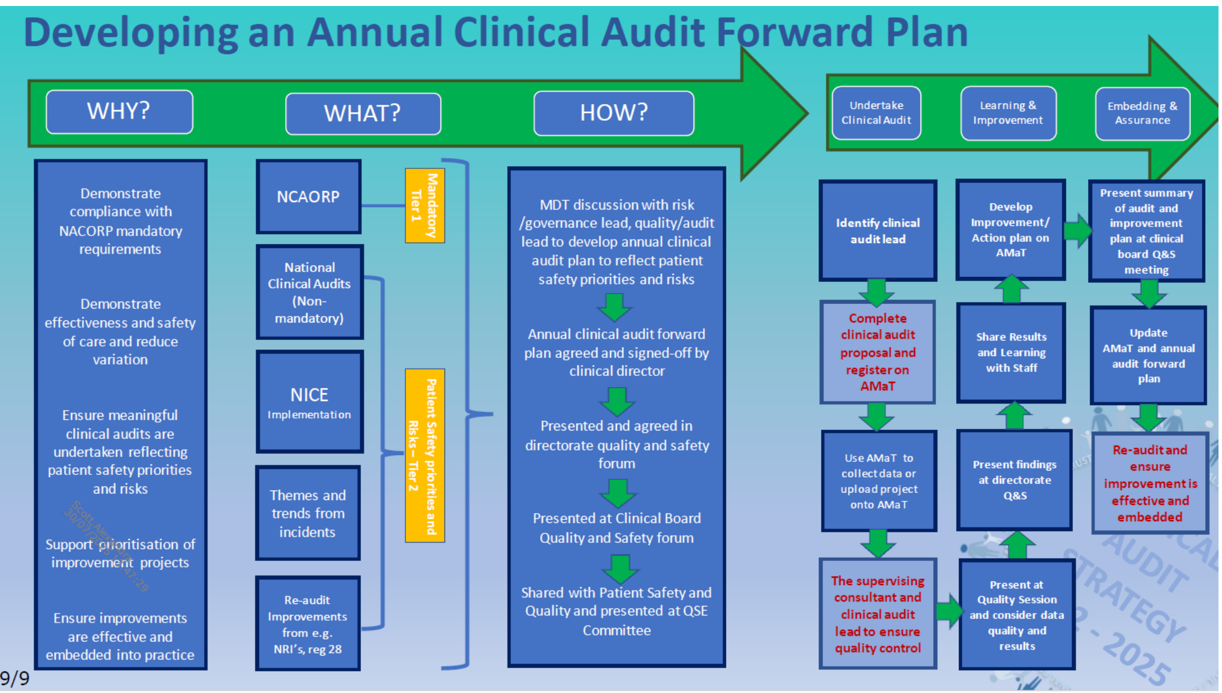
Governance Route *(please list all other Committee/Groups this report has been to)*

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

Main Report
Background & Current Situation

The Health Board's Clinical Audit Policy and Strategy set out an organisation-wide approach to using clinical audit as a key component of a quality management system, providing assurance on compliance with evidence-based standards while driving continuous improvement in patient outcomes and safety. Central to this approach is the requirement for each Clinical Board to develop and maintain a robust, clinical audit

forward plan that is owned by services and aligned to patient safety priorities, risks, regulatory requirements and national audit programmes, ensuring that audit activity is focused on what matters most for quality and patient safety and supports the Board's overall assurance framework.



To support compliance with these requirements, Cardiff and Vale University Health Board has developed an Annual Audit Forward Plan for 2026/2027 (Appendix 1), which sets out the planned audit programme across the organisation. The audit plan is dynamic and will continue to develop throughout the year. The plan includes both Tier 1 and Tier 2 audits:

- Tier 1 audits comprise national clinical audits mandated by Welsh Government.
- Tier 2 audits are locally determined audits aligned to patient safety priorities, including emerging themes and trends identified through incident reporting, concerns and complaints, HIW inspections and Nationally Reportable Incidents.

Tier 1

The annual National Clinical Audit and Outcomes Review Plan published by NHS Wales sets out the National Clinical Audits in which all Health Boards and NHS Trusts in Wales are required to participate. Health Boards are expected to facilitate full engagement in the programme and to ensure that audit findings and recommendations are effectively reviewed and translated into improvements in the quality and safety of patient care. The Health Board participates in all of the relevant audits, however, the approach taken to facilitating these audits varies between specialities with some directorates appointing dedicated audit facilitators to work with the clinical teams and in other areas data is collected by the clinicians. As a result case ascertainment and data quality can be impacted in directorates where data collection arrangements are less resilient and remains a risk to the organisation.

The outcomes of all national audits are presented at the UHB Clinical Effectiveness Committee where audit leads present the findings, learning, and recommendations arising from national clinical audits. Attendance from Clinical Board representatives is encouraged to support organisational assurance regarding compliance with national audit requirements. The Committee also provides an opportunity to identify challenges, risks, and barriers to implementation, and to agree appropriate support or escalation where required.

Tier 2

The Audit Forward Plan has been developed with Clinical Boards and Directorates to ensure alignment with local priorities. Tier 2 clinical audits have been planned to meet regulatory requirements, to provide assurance in relation to areas of improvement implemented as a result of patient safety incidents, Healthcare Inspectorate Wales recommendations or to provide assurance around service delivery in line with national guidance.

A significant proportion of audits are registered on the Audit Monitoring and Tracking (AMaT) system, which is used by the Health Board to monitor audit progress, record findings, and provide supporting evidence of completion.

In specific clinical areas, particularly highly regulated specialities, including Radiology, Laboratory Services, and Blood Transfusion, Q-Pulse is used to monitor and manage audit activity. In addition, the Health Board utilises Tendable, which supports a well-established programme of ongoing digital audits.

Within each Clinical Board, local audit meetings are held to review audit activity and support the dissemination of learning and best practice across services.

The UHB Clinical Audit Policy and Strategy is currently being refreshed and will strengthen the governance and oversight of the outcome of clinical audits and will align the strategy to the developing UHB quality management system.

Progress with the Clinical audit plan will be monitored through the Clinical Effectiveness Committee with Clinical Boards providing periodic updates.

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

- **2026/2027 Clinical audit forward plan**

Strategic Alignment – Shaping Our Future Wellbeing:

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

Impact Assessment
Risk: No
Safety: Yes

Clinical audit is an important tool supporting quality, All of the tier 1 and 2 audits are undertaken to support national benchmarking or are scheduled to support the quality and patient safety priorities of the Clinical Boards
Financial: No
Workforce: No
There are groups of health professional across the organisation who are required to participate in audit and quality improvement projects in order to support their annual appraisal / validation. The clinical audit forward plan supports an approach to identifying clinical audit projects that are both meaningful and can add value to the organisation.
Legal: No
Reputational: Yes
Full participation in national clinical audits is required to support benchmarking and national learning. Non-participation remains a risk for the Health Board due to challenges in resources these audits.
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: Yes
Some of the National clinical audits provide oversight of health inequalities and can therefore inform planning of future services to eradication variation in outcomes.
Decarbonisation: No
Welsh Language: No

Audit forward plan 2026/2027

Title	Clinical Board	Level of Audit	Lead Clinician	Last reported in CEC	Date for next presentation in CEC	Comments	AMaT, Tendable, QPulse?	Publication date (subject to change)
National Audit of Dementia (NAD)	Corporate	Tier 1	Dr Jennifer Clarke	21.01.2026	Jan-27	Census spot day in June	AMaT	14.05.2026
National Audit of Eating Disorders (NAED)	Mental Health	Tier 1				Not currently in Wales, aiming to start collecting data in 2027		
National Clinical Audit of Psychosis (NCAP)	Mental Health	Tier 1	Norman Young/Emily Harrington	30.01.2026	Jan-27		AMaT	08.10.2026
National Audit of Care at the End of Life (NACEL)	PCIC	Tier 1	Hannah Osborn	16.04.2026	Aug-27		AMaT	13.08.2026. August 2027
National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	Mental Health	Tier 1	No Lead			Data only. Not a national audit.		08.10.2026
Falls and Fragility Fracture Audit (included hip fracture database) (FFFAP) includes National In-patient Falls NAIF)	Surgery	Tier 1	Anthony Johansen / Kathryn Crawford (NAIF)	21.01.2026	Jan-27		AMaT	NHFD 10.09.2026 and Sept 2027, NAIF 08.10.2026 and Oct 2027
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	PCIC	Tier 1				I've emailed Richard Baxter for info.	AMaT	10.12.2026, 09.12.2027
National Audit of Metastatic Breast Cancer (NAoMe)	Surgery	Tier 1	Ms Anna Powell-Chandler	22.10.2025	23.09.2026		AMaT	10.09.2026
National Audit of Primary Breast Cancer (NAoPri)	Surgery	Tier 1	Ms Anna Powell-Chandler	22.10.2025	23.09.2026		AMaT	09.10.2026, 09.10.2027
National Bowel Cancer Audit (NBoCA)	Surgery	Tier 1	Mr James Ansell	22.10.2025	16.10.2026		AMaT	08.10.2026
National Cardiac Audit Programme (NICOR) PFO	Specialist	Tier 1	Dr Vaseem Farooq	16.04.2026	Apr-27		AMaT	TBC
National Clinical Audit of Perioperative Care (NCAPC)	Surgery	Tier 1				Newly commisioned, data collection starting Oct 2026.	AMaT	TBC
National Early Inflammatory Arthritis Audit (NEIAA)	Medicine	Tier 1	Ruth Davies	16.04.2026	Apr-27		AMaT	08.10.2026

National Emergency Laparotomy Audit (NELA)	Surgery	Tier 1	Sara Churchill	24.01.2025	29.04.2026		AMaT	NoLap 14.05.2026, EmLap 08.10.2026
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy 12)	C&W	Tier 1	Dr Demetria Demetriou		19.06.2026		AMaT	09.07.2026
National Kidney Cancer Audit (NKCA)	Specialist	Tier 1					AMaT	TBC
Renal Registry	Specialist	Tier 1	Dr Aled Lewis	07.07.2025	15.07.2026		AMaT	Jun-27
National Lung Cancer Audit (NLCA)	Medicine	Tier 1	Dr Craig Dyer	22.10.2025	16.10.2026		AMaT	09.07.2026
National Maternity and Perinatal Audit (NMPA)	C&W	Tier 1	Lucie Lewis	18.03.2026	Mar-27		AMaT	13.08.2026
National Neonatal Audit Programme (NNAP)	C&W	Tier 1	Dr Nitin Goel	18.03.2026	Mar-27	Benchmarking	AMaT	08.10.2026
National Non-Hodgkin Lymphoma Audit (NNHLA)	Specialist	Tier 1	No lead			Data only	AMaT	Awaiting confirmation from HQIP
National Obesity Audit		Tier 1				? not contributing	AMaT	TBC
National Oesophogo-Gastric Cancer Audit (NOGCA)	Medicine	Tier 1	Dr Tarig Abdelrahman	22.10.2025	16.10.2026		AMaT	10.09.2026
National Ovarian Cancer Audit (NOCA)	C&W	Tier 1	Ms Sadie Jones	07.07.2025	23.09.2026	Data only	AMaT	11.06.2026
National Pregnancy in Diabetes Audit NPID	C&W/Medicine	Tier 1	Dr Aled Roberts/Dr Linsay George	18.03.2026	Mar-27		AMaT	TBC via HQIP
National Pancreatic Cancer Audit (NPaCA)	Surgery	Tier 1	Ms Trish Duncan	07.07.2025	16.10.2026		AMaT	10.09.2026
National Prostate Cancer Audit (NPCA)	Surgery	Tier 1	No lead (? Nicholas Bullock Ca lead Urology new in post)	22.10.2025	16.10.2026	No clinical lead in Health Board, I've emailed NB	AMaT	09.07.2026
National Vascular Registry (NVR)	Surgery	Tier 1	Mr Lewis Meecham		29.04.2026		AMaT	12.11.2026
Paediatric Intensive Care Audit Network (PICANet)	C&W	Tier 1	Dr Siva Oruganti	22.03.2024	19.06.2026		AMaT	10.12.2026
Sentinal Stroke National Audit Programme (SSNAP)	Specialist	Tier 1	Stroke Service Manager Niki Turner	24.01.2025	15.07.2026		AMaT	TBC via HQIP
National Joint Registry	Surgery	Tier 1	Mr Alun John	24.01.2025	29.04.2026		AMaT	Sep-26

Intensive Care National Audit and Research (ICNARC)	Specialist	Tier 1	Dr Gareth Scholey	07.07.2025	15.07.2026		No	TBC
National Major Trauma Registry (previously TARN)	Specialist	Tier 1	Dr Matthew Creed	07.07.2025	15.07.2026		AMaT	TBC via HQIP
Audiology Quality Standards	Surgery	Tier 1	Lorraine Lewis	25.02.2026	Feb-27		No	Aug-26
Perinatal Mortality Review Tool (PMRT)	C&W	Tier 1	Dr Nitin Goel	18.03.2026	Mar-27		AMaT	11.06.2026
Monthly Tendable audits - Theatres	Surgery	Tier 2	Barbara Jones Practice Development Nurse	N/A	N/A	Monthly schedule of audits, including IP&C, core standards, VTE, Consent and laterality, Medicine management. Lloyd Davies positioning, POCT, Uniform. QUAD	Tendable	N/A
Chronic Obstructive Pulmonary Disease (COPD) secondary care audit	Medicine	Tier 1	Dr Ramsey Sabit	08.08.2025	21.08.2026		AMaT	30.06.2027
Adult Asthma Audit	Medicine	Tier 1	Dr Katie Pink / Dr Alison Whittaker	08.08.2025	21.08.2026		AMaT	30.06.2027
Pulmonary rehabilitation Audit	Medicine	Tier 1	Tom Lines	08.08.2025	21.08.2026		AMaT	30.06.2028 - combined clinical audit report 26/27
Paediatric Secondary Care Audit	C&W	Tier 1	Daniel Rigler	08.08.2025	21.08.2026		No	
Primary Care COPD	PCIC	Tier 1	Richard Baxter	08.08.2025	21.08.2026		AMaT	14.05.2026
National audit of Mitral Valve Leaflet Repairs (MVLR)	Specialist	Tier 1	Dr Richard Anderson	04.02.2026	26.11.2026		AMaT	TBC
UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Specialist	Tier 1	Dr Richard Anderson	04.02.2026	26.11.2026		AMaT	TBC
National Adult Cardiac Surgery	Specialist	Tier 1	Prof Indu Deglurker	04.02.2026	26.11.2026		AMaT	TBC
Fracture Liaison Database	Surgery	Tier 1	Dr Jack Boylan	21.01.2026	Jan-27		AMaT	10.09.2026
Maternity and Neonatal Safety Support Programme (MatNeoSSP)	C&W	Tier 1	Lucie Lewis	18.03.2026	Mar-27		No	
NCEPOD Emergency surgery in children and young people - ESCYP	C&W	Outcome review programme			19.06.2026			
National Diabetes Footcare Audit	CD&T	Tier 1	Head of Podiatry Vanesssa Goulding	21.05.2025	22.05.2026		AMaT	TBC via HQIP

National Diabetes Inpatient Safety Audit	Medicine	Tier 1	Dr Julia Platts	21.05.2025	22.05.2026	C&V hasn't been able to particpate as lacks digital capacity to collect data.	AMaT	TBC via HQIP
Core National Diabetes Audit	Medicine	Tier 1	Dr Sarah Davies	21.05.2025	22.05.2026		AMaT	TBC via HQIP
National Paediatric Diabetes Audit (NPDA)	C&W	Tier 1	Dr Ambika Shetty	21.05.2025	22.05.2026		AMaT	Mar-27
National Audit of Cardiac Rhythm management NACRM	Specialist	Tier 1	Dr Peter O'Callahan	28.11.2025	26.11.2026		AMaT	TBC
National Heart Failure Audit	Specialist	Tier 1	Prof Zaheer Yousef	28.11.2025	26.11.2026		AMaT	TBC
National Audit of Percutaneeous Coronary Interventions (NAPCI)	Specialist	Tier 1	Dr Majd Protty	28.11.2025	26.11.2026		AMaT	TBC
National Audit of Cardiac Rehabilitation (NACR)	Specialist	Tier 1	Clinical Lead Angela Melvin		26.11.2026		AMaT	April, July, September & December 2028
Myocardial Ischaemia National Audit Programme MINAP	Specialist	Tier 1	No Lead		26.11.2026		AMaT	TBC
National Congenital Heart Disease Audit (NCHDA)	Specialist	Tier 1	Prof Orhan Uzun	28.11.2025	26.11.2026		AMaT	TBC
72 hr follow up	Mental Health	Tier 2	Chris Frayne Sr Nurse Adult MH	N/A		Theme from NRIs	No	
Wales Applied Risk Research Network (WARRN)	Mental Health	Tier 2	Radhika Oruganti Consultant Psychiatrist	N/A		Theme from NRIs	No	
Care and Treatment Plan	Mental Health	Tier 2	Radhika Oruganti Consultant Psychiatrist	N/A		Theme from NRIs	No	
Prescribing Observatory for Mental Health (POMH)	Mental Health	Tier 1	Specialist MH Pharmacist	N/A		There are usually 4 audits each year	AMaT	TBC
Gestational Diabetes Audit	C&W/Medicine	Tier 1		N/A		C&V not collecting data atm. PST and maternity to meet to agree how to collect data	AMaT (not 26/27)	N/A
Child health clinical outcome review programme	C&W	Tier 1				Not collecting data 2025/26		
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	C&W	Tier 1	Dr Nitin Goel	18.03.2026	Mar-27	Benchmarking		11.06.2026

National Comparative Audit on the use of prophylactic anti-D in pregnancy	C&W/CD&T	Tier 1	Transfusion Practitioner Samantha McWilliam	N/A	2027	New audit	AMaT	30.10.2026
Consent for surgery	Surgery	Tier 2	Barbara Jones Practice Development Nurse	N/A	N/A	Part of the Tendable theatre audit programme	Tendable	N/A
Blood transfusion QMS Audit p	CD&T	Tier 1	Audit Lead	N/A	N/A	Please see Q Pulse report	Q Pulse	N/A
Lab QMS Audit programme	CD&T	Tier 1	Audit Lead	N/A	N/A	Please see Q Pulse report	Q Pulse	N/A
Aseptic pharmacy services QM	CD&T	Tier 1	Audit Lead	N/A	N/A	Please see Q Pulse report	Q Pulse	N/A
Radiology QMS Audit program	CD&T	Tier 1	Audit Lead	N/A	N/A	Please see Q Pulse report	Q Pulse	N/A
Monthly Tendable audit MHSOP	Mental Health	Tier 2	Lead and Sr Nurse MHSOP	N/A	N/A	Monthly schedule of audits, including IP&C, core standards, Physical health monitoring, patient handling, WARRN (risk assessment), Medicine Management, Diabeites and Point of Care Testing (POCT), Patient Information Displays, Mealtimes and nutrition, NEWS2	Tendable	
Monthly Tendable audit - adult inpatient areas	Medicine, Surgery, Specialist	Tier 2		N/A	N/A	Monthly schedule of audits, including Falls, bowel care, manual handling, pressure damage, Medicine managements, Diabetes, PICT, Pain, Fluid balance, Mouthcare, Mealtimes and nutrition, NG, Get up, Get dressed, Get moving, Patient observations, Continence, Catheter care, Commodes cleanliness	Tendable	N/A
Monthly Tendable audit - paediatric inpatient areas	C&W	Tier 2		N/A	N/A	Monthly schedule of audits, including bowel charts, patient handling, pressure damage, medicine management, POCT, pain mangement, mouthcare, mealtimes and nutrition, PEWS, NEWTT2, Catheter care, commode cleanliness	Tendable	
Monthly Tendable audit - MH inpatient areas	Mental Health	Tier 2	Lead and Sr Nurse Adult MH	N/A	N/A	Monthly schedule of audits, including physical health monitoring, patient handling, patient information displays, WARRN, Medicine management, Diabetes and POCT, NEWS2,	Tendable	
Radiology **cancer audit - notification process of imaging reports (relates to NRIs)	CD&T	Tier 2	Harry Warring, Rwth Ellis Owen	N/A	N/A	Date collection 01.01.2026 - 13.04.2026	AMaT	

NEWS2, AKI recognition and fluid management	Corporate team	Tier 2				NRI 96379	No	
Acute Kidney Injury Recognition	Corporate team	Tier 2						
Fluid Management	Corporate team	Tier 2						
Audit of documentation in OpenEyes, inc visual acuity, OCT scans	Surgery	Tier 2	Ophthalmology	N/A	N/A	NRI 92434, 97841	No	N/A
Biopsy rates, cancer detection timelines, and adherence to guidelines.	C&W	Tier 2	Clinical Risk Lead Gynaecology	N/A	N/A	NRI 63524	No	N/A
Audit of the modified WHO surgical safety checklist for assisted vaginal births in the birthing room	C&W	Tier 2	Obstetrics	N/A	N/A	NRI 76056 No uploaded evidence	AMaT imp plan	N/A
Use of the predisposing column information included by staff when using a Wales Applied Risk Research Network (WARRN) in an inpatient setting	MH	Tier 2	Psychology and Psychological Therapies	N/A	N/A		AMaT	N/A
Audit of use of EIDO leaflets or other validated consent support information leaflets	C&W	Tier 2	Clinical Lead for Gynaecology and Governance team	N/A	N/A	NRI 85546	No	N/A
Audit of handover and transfers in EU	Medicine	Tier 2	Lead Nurse			NRI 90465	No	N/A
Snapshot audit of NEWS2 use in Endoscopy Unit	Medicine	Tier 2	Lead/Sr Nurse covering Endoscopy Unit	N/A	N/A	NRI 95833. Audit completed April, plan is for monthly audits	Tendable	N/A
Monthly audits of WARRN assessments	MH	Tier 2	Lead and Sr Nurses		Imp plan on AMaT	NRI 90122, 90158		N/A
Audit tool to be developed to track adherence to local SOP for STEMI policies	Specialist	Tier 2	Cardiology Directorate Management Team	N/A	N/A	NRI 47930	No	N/A

Audit of STEMI referrals	Specialist	Tier 2	Interventional M&M lead - Cardiology	N/A	N/A	NRI 47930	No	N/A
Audit of current activity and performance standards to include time to diagnostic angiography for ACS and Time to CABG	Specialist	Tier 2	Cardiology Directorate Management Team	N/A	N/A	NRI 72016	No	N/A
Monthly audit of CPO screening within Nephrology and Transplant	Specialist	Tier 2	N&T Directorate team	N/A	N/A	NRI 80625	No	N/A
Audit of the CP01 Referral Triage Document	Surgery	Tier 2	Digital/Clinical Leads Spines	N/A	N/A	NRI 79258	No	N/A
Regular audits of pooled lists to ensure equity of access	Surgery	Tier 2	Service Manager / Admin Team Spines	N/A	N/A	NRI 79258	No	N/A
Audit adherence to South Wales Spinal Network (SWSN) Clinical Pathway	Surgery	Tier 2	Service Manager Spines	N/A	N/A	NRI 79258	No	N/A
Periodic audit of manuel printed patient letters in Breast services to verify compliance and identify any process gaps	Surgery	Tier 2	T&O&Breast Directorate Management Team	N/A	N/A	NRI 90145	AMaT (imp plan Surgical action log)	N/A
Audit all Wales Clinical Communications Gateway failed letters on a monthly basis to ensure that any letters rejected by the system have been successfully sent to the intended recipient and confirmed via a follow-up phone call.	Surgery	Tier 2	T&O&Breast Directorate Management Team	N/A	N/A	NRI 90145	AMaT (imp plan Surgical action log)	N/A
Audit completion of Discharge Advice Letters (DALS) for the month of January 2026	Surgery	Tier 2	Directorate Management Team Urology	N/A	N/A	NRI 91732	No	N/A
Monthly audit of radiology requests to include completion of demographic details	CD&T	Tier 2	Radiology			NRI 101729	No	N/A

Intermittent ward Senior and Lead nurse IPC environment spot check audits.	Mental Health	Tier 2	Service Manager	N/A	N/A	Maple Ward Healthcare Inspectorate Wales (HIW)/2025/1015 Inspection improvement plan	Tendable	N/A
Twice daily environmental audit	Mental Health	Tier 2	Service Manager	N/A	N/A	Maple Ward Healthcare Inspectorate Wales (HIW)/2025/1015 Inspection improvement plan	Tendable	N/A
Audit of segregation documentation in HMP	PCIC	Tier 2	Lead Nurse	N/A	N/A	NRI 78736	No	N/A
HCR 20 (risk assessment) documentation audit	Mental Health	Tier 2	Senior Nurse Forensic Services	N/A	N/A	Maple Ward Healthcare Inspectorate Wales (HIW)/2025/1015 Inspection improvement plan. Training has been delivered by Clinical Psychologist to use HCR 20. This training is also being delivered to the community and wider MDT. A rolling improvement and audit programme will follow this to ensure HCR 20 documentation is completed.		N/A
Audit of Training Passport for healthcare staff in HMP	PCIC	Tier 2	Lead Nurse	N/A	N/A	NRI 78736	No	N/A
Documentation audit in relation to the supply of Patient Group Directive medication	PCIC	Tier 2	Lead Nurse and Lead Pharmacist	N/A	N/A	NRI 78736	No	N/A
Recording of Next of Kin details audit	Mental Health	Tier 2	Integrated Manager CMHT	N/A	N/A	Hamadryad CMHT Healthcare Inspectorate Wales (HIW)/2025/1021. Compliance will be audited quarterly as a minimum. The next audits will take place in June 2025 and December 2025.	AMat inspection module	N/A
Medication adminstration record keeping audit	Mental Health	Tier 2	Integrated Manager CMHT	N/A	N/A	Hamadryad CMHT Healthcare Inspectorate Wales (HIW)/2025/1021. Compliance will be audited quarterly as a minimum. The next audits will take place in June 2025 and December 2025.	AMat inspection module	N/A
Induction of temporary staff/ agency staff	Mental Health	Tier 2	MHSOP	N/A	N/A	NRI 86705 AMaT Inspection module MHSOP - GR (evidence is the checklist)	AMaT inspection module	N/A

Quarterly Care and Treatment Plan (CTP) audits	Mental Health	Tier 2	Lead Health Practitioner	N/A	N/A	Hamadryad CMHT Healthcare Inspectorate Wales (HIW)/2025/1021. Quality audits for CTP are conducted quarterly with feedback discussed in MDT meeting.	AMat inspection module	N/A
Monthly observational audit of call bell response times	Medicine	Tier 2	Ward Manager	N/A	N/A	Healthcare Inspectorate Wales (HIW)/2025/1022. Elizabeth Ward. All staff on the ward have been reminded of the importance of responding to patient call bells in a timely manner. Monthly observational audits will be undertaken by Ward Manager, Deputy and Senior Nurse to ensure good practise.	AMaT inspection module	N/A
Audit to monitor adherence to needling protocols, complication rates and patient outcomes	Specialist	Tier 2	N&T Directorate team	N/A	N/A	NRI 58684	No	N/A
Compliance with the new documentation standards, the use of drain reconciliation checklists, and the consistent application of the double-suture technique.	Surgery	Tier 2	Perioperative	N/A	N/A	NRI 85432	AMaT (imp plan Surgical action log)	N/A
Quarterly Audit: Referrals and Appointments for Trial Without Catherter /Clinic Catheter Changes & Booking time check	Surgery	Tier 2	Urology	N/A	N/A	NRI 85779	AMaT (imp plan Surgical action log)	N/A
Monthly Senior Nurse audit of use of 'I am clean' stickers on equipment	Medicine	Tier 2	Senior Nurse	N/A	N/A	Healthcare Inspectorate Wales (HIW)/2025/1022. Elizabeth Ward.	AMaT inspection module	N/A
Weekly Ward/Deputy Ward Manager expired medication auidt	Surgery	Tier 2	Ward Manager	N/A	N/A	SSSU Healthcare Inspectorate Wales (HIW)/2026/1126	AMat inspection module	N/A
Weekly Ward/Deputy Ward Manager audit to ensure all medication fridge items are labelled	Surgery	Tier 2	Ward Manager	N/A	N/A	SSSU Healthcare Inspectorate Wales (HIW)/2026/1126	AMat inspection module	N/A

Daily PPDN audit to monitor compliance with decontamination of BP cuffs	Surgery	Tier 2	PPDN	N/A	N/A	SSSU Healthcare Inspectorate Wales (HIW)/2026/1126	AMat inspection module	N/A
Weekly spot check audit of IPC waste-disposal regulations	Surgery	Tier 2	Senior Nurse	N/A	N/A	SSSU Healthcare Inspectorate Wales (HIW)/2026/1126	AMat inspection module	N/A
Monitoing of IPC audits on Tendable by Senior Nurse	Surgery	Tier 2	Senior Nurse	N/A	N/A	SSSU Healthcare Inspectorate Wales (HIW)/2026/1126	AMat inspection module	N/A
Monitoring of compliance with pressure ulcer risk assessment for patients in the Dept. for more than 24 hours	Surgery	Tier 2	Senior Nurse	N/A	N/A	SSSU Healthcare Inspectorate Wales (HIW)/2026/1126	AMat inspection module	N/A
Fluid balance documentaion audit	Surgery	Tier 2	PPDN	N/A	N/A	SSSU Healthcare Inspectorate Wales (HIW)/2026/1126	AMat inspection module	N/A
Six monthly audit of fluid balance and nutritional risk assessment compliance.	Surgery	Tier 2	Senior Nurse	N/A	N/A	SSSU Healthcare Inspectorate Wales (HIW)/2026/1126	AMat inspection module	N/A
Weekly audit of confidential wate bins to ensure they are not overflowing	Surgery	Tier 2	Senior Nurse	N/A	N/A	SSSU Healthcare Inspectorate Wales (HIW)/2026/1126	AMat inspection module	N/A
Audit of signage to ensure its dementia friendly	C&W	Tier 2	Senior Nurse	N/A	N/A	B2 Link HIW Inspection	AMat inspection module	N/A
Senior Nurse audit of compliance with the use of the green stickers/tape for equipment cleaning	C&W	Tier 2	Senior Nurse	N/A	N/A	B2 Link HIW Inspection	AMaT inspection module	N/A
Monthly tendable audit - District Nursing - ANTT Audit Uniform audit Case note Compliance Catheter Competency/Educational Audit Handwashing Nursing Home - Risk Assessment/Documentation Audit	PCIC	Tier 2	Team Leader/Sr Nurse	N/A	N/A		Tendable	N/A

PARIS monthly audits of DN performance includng NEWS, careplans, risk assessment, nursing assessment	PCIC	Tier 2	Team Leader/Sr Nurse	N/A	N/A		PARIS	N/A
Audit (clinical and non-clinical) of telephone contacts in line with national OOH audit guildelines for CAV24/7	PCIC	Tier 2	Lead Nurse ICCS	N/A	N/A	Plan is to add the audit programme to Tendable		N/A
Monthly audits for Immunisation, DOSH, CAVHIS and HMP - includes core standards, IP&C and for HMP; reception screening and record keeping	PCIC	Tier 2	Lead Nurse Health Inclusion and Health Protection	N/A	N/A	Plan is to add the audit programme to Tendable		N/A
Royal College of Emergency Medicine audits	Medicine	Tier 2	Audit Lead Emergency Medicine	N/A	N/A		No	
Society for Acute Medicine Benchmarking Audit SAMBA	Medicine	Tier 2	Audit Lead Acute Medicine	N/A	N/A		No	
Audit validation system between Vital Data (VD) and Organ Donation and Transplantation (ODT	Specialist	Tier 2	Renal IT Lead. Renal Transplant Lead	N/A	N/A	NRI 90695	No	N/A
NCEPOD Acute sigmoid volvulus	Surgery	Tier 1		N/A	2027	Data collection to begin summer 2026		
NCEPOD Necrotising enterocolitis	C&W	Tier 1	Governance Lead for Neonatal Unit	N/A	2027	Data collection to begin summer 2026		
NCEPOD Delirium	Medicine	Tier 1		N/A	2027	Data collection to begin winter 2026		
Audit of pacemaker recall and battery check processes	Specialist	Tier 2	Cardiology Directorate Management Team	N/A	N/A			
Audit of pacemaker insertion Locsip/SOP	Specialist	Tier 2	Cardiology Directorate Management Team	N/A	N/A			
National Neuromodulation Registry	Specialist	Tier 1	Neurosciences				AMaT	
Vestibular Schwannoma Registry	Specialist	Tier 1	Neurosciences				AMaT	

CLINICAL BOARD QUALITY UPDATE REPORT

Governance Group:	Medicine Clinical Board	**Date of Meeting:**	15 April 2026
Representative at Clinical Board Governance:	Jane Murphy	**Date of Meeting:**	

ITEMS FOR ALERT

Issue / Risk	Actions Taken	Group Responsible
Sepsis - Several NRIs have sepsis at the centre of the concern, predominantly at the beginning of the patient journey within ED. However, failure to recognise deterioration is also a theme. Initial scoping discussions have commenced, including appointment of Tim Ayres as Sepsis Lead in ED as well as the reignition of the CAV-wide Sepsis Working Group.	A programme of improvement is underway including within the Sepsis working group: • UK Sepsis “Train the Trainers” course with planned wider rollout across wards. This is a great opportunity to benefit from on offer training and as a Board we need to engage with this and will need support from our senior nurses. • Sepsis seminar (June 2026), Lyndsey McDonald (Clinical Director for Quality & Safety) will be presenting current Medicine Clinical Board themes and improvement work. Tim Ayres also presenting.	Sepsis Working Group
Falls - incident and thematic concerns: recent patient safety incident discussed in QSE highlights gaps in risk assessment, documentation, and supervision (particularly around bed rail use and reliance on family presence).	- Development of a quarterly falls newsletter to share learning and trends - Reinforcement of falls action cards in clinical areas - Ongoing focus on improving the quality and consistency of documentation to support prevention and provide assurance of care standards	Quality Lead MCB/Lead Nurses
Mental Capacity Act (MCA) - the MCA audit identifies significant patient safety and legal compliance risks due to inconsistent application of statutory processes, poor documentation, and low training uptake throughout the UHB. Without a clear and practical implementation plan, there is a high risk of continued non-compliance, staff disengagement, and inability to provide organisational assurance.	• Develop and implement a Clinical Board MCA improvement plan • Align the plan to clear priorities: statutory compliance (capacity assessments and DoLS), documentation standards, and training delivery. • Introduce a tiered training approach to improve accessibility and uptake, including:	Clinical Board QSE Leads

	• Short, flexible sessions (30–60 minutes / bite-size) • 7-minute briefings to reinforce key principles • Targeted ward-based sessions and delivery via team/away days • Prioritise high-risk areas and teams with lowest compliance for immediate rollout.	
IPC - pressures (Norovirus outbreaks). Ongoing outbreaks have resulted in significant bed closures and operational pressure, with transmission across patients and staff.	IPC action plan devised and implemented – Focus on reducing HCAI risk through care bundles, data availability and transparency, RCA learning and shared learning, winter infection preparedness	Deputy Director of Nursing

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group Responsible**
NRI position and trajectory – currently have a number of overdue NRI's	Overall position improving, with a reduction in overdue NRIs. Work continues to reduce backlog and strengthen timeliness of reviews. Good uptake on the training session, and we are seeing engagement with wider members of MCB (EM have to date often been more significant contributors to this workload). We now have a robust meeting structure weekly to monitor progress of NRI's	Director of Nursing/Quality Leads MCB
Coronial activity and learning	AD: Inquest complete (narrative verdict). Learning identified around cross-system working; improvements underway in collaboration with PCIC, including SOP development (currently for approval). AF: Inquest complete (narrative verdict). AR: Inquest scheduled for 3 July 2026.	Clinical Director for Quality & Safety

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

QSE SOP (Clinical Board governance) New Quality, Safety & Experience SOP providing: • Standardised approach to governance across directorates • Clear definition of roles, responsibilities, and processes (incidents, PSLR, NRI, risk) • Improved visibility of ownership and oversight	For presenting to QSE MCB 20 May 2026 for comment and review	Clinical Director for Quality & Safety (MCB) Quality Lead MCB/Director of Nursing

RECENT LEARNING OPPORTUNITY			
Source:		**Reference (if applicable):**	

What happened / what was the problem?

Patient story discussed - Elderly patient admitted to the Emergency Department with suspected infection and mild confusion, who sustained a fall from a trolley overnight in the Majors area. This resulted in a left intertrochanteric femoral fracture and a prolonged hospital stay. Although initial falls risk assessments were completed and the patient's daughter was present throughout, there was a lack of clear documentation and regular review regarding decisions to disengage trolley side rails, and supervision requirements were not reassessed as the patient's condition and circumstances changed. The fall occurred while the patient was asleep with the side rail lowered, following earlier mobilisation to the toilet at the daughter's request. Contributing factors included inconsistent documentation of mobility status, over-reliance on family support, and insufficient risk-based reassessment. The harm was initially graded as low, which led to delays in escalation, clinical review, and implementation of the Duty of Candour, thereby increasing distress for both the patient and her family.

What was learned and how was this shared?

An update was provided by Ruth Cann on the bed rail procedure, which will be presented to the Falls Delivery Group, alongside newly available All-Wales bed rail assessment training via ESR. The training is designed to be straightforward, compliant, and supportive in addressing known gaps in assessment practice.

It was confirmed that bed rails are already included within the current action plan, with an offer to share and refine this further if required.

A wider discussion highlighted ongoing challenges in:

- Classifying harm from falls at the point of incident reporting, where staff rely on professional judgement that is often refined following investigation
- Consistency of incident reporting, particularly among bank staff, with recognition that traditional training approaches may be difficult to deliver. As an alternative, regular data review and validation ("cleansing") was suggested as a more practical approach

Key recurring themes identified across incidents:

- Strengthening falls prevention practices, particularly documentation quality
- Ensuring clear recording of discussions with patients and families
- Appropriate use of bed rails and bed height management
- Improving the quality and consistency of risk assessments and preventative actions

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

- Development of a quarterly falls newsletter to share learning and trends
- Reinforcement of falls action cards in clinical areas
- Ongoing focus on improving the quality and consistency of documentation to support prevention and provide assurance of care standards

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

MCB has enhanced NRI management with clearer oversight and prompt escalation for Reviewers. A RAG rating now flags NRIs six weeks before they are due (yellow), allowing weekly reviews alongside overdue items to ensure scrutiny and timely monitoring.

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:	Surgery Clinical Board QSE	**Date of Meeting:**	19th May 2026
Representative at Clinical Board Governance:	Director of Nursing	**Date of Meeting:**	

ITEMS FOR ALERT

Issue / Risk	Actions Taken	Group Responsible
Estates and environmental risks have been identified in several key areas, including A6 North, SDEC, Dental, and Theatre environments. These risks pose significant challenges to daily operations and the overall safety within these locations. The presence of these risks directly affects infection prevention and control (IPC), compromises safety measures, and has a negative impact on both patient and staff experience. It is essential to address these issues promptly to maintain a safe and effective care environment.	Immediate remedial works undertaken (e.g. A6 North toilet improvements; SDEC IPC remediation actions) - Estates issues escalated via multiple routes including HIW response and MRs - Ongoing monitoring and re-audit requested where appropriate	SCB QSE and H&S
Unsent Discharge Advice Letters (DALs) on ePMA creating risk There is a risk arising from unsent Discharge Advice Letters (DALs) within the electronic Prescribing and Medicines Administration (ePMA) system. This issue has the potential to impact patient safety and care continuity, as discharge advice may not reach the appropriate recipients in a timely manner. The presence of unsent DALs can lead to gaps in communication, affecting both clinical outcomes and operational effectiveness.	- Risk formally added to Clinical Board risk register - Work underway to develop dashboard visibility by specialty/team - Expectation for local management and oversight introduced	SCB QSE
The recent audit of the Mental Capacity Act (MCA) has highlighted substantial risks to both patient safety and legal compliance across the University Health Board (UHB). The key concerns identified include the inconsistent application of statutory processes, which may result in failure to uphold patient rights and safeguard standards. Additionally, poor documentation practices have been observed, compromising the clarity and accuracy of patient records. The audit also noted a low uptake of MCA training among staff, suggesting gaps in awareness and understanding of legal responsibilities relating to mental capacity. These issues collectively pose significant risks and need to be addressed to ensure compliance and improve outcomes for patients within the UHB.	Audit conducted (Jan 2026) identifying significant gaps - Training programme revised (practical application, webinars, leadership programmes) - Development and promotion of proformas and SOPs - Proposal to implement local champions and targeted workforce approach Develop and implement a Clinical Board MCA improvement plan 7-minute briefings to reinforce key principles	Clinical Board QSE Leads

ITEMS TO ADVISE

Issue / Risk	Actions Taken	Group Responsible
Perioperative Ketone Monitoring Protocol for Patients Receiving SGLT2 Inhibitors	New clinical pathway developed and presented - Supported by Anaesthetics, Pharmacy, and Diabetes teams - Clinical Board supportive of	Advice was requested from the UHB governance team as where to host.

	implementation pending confirmation of governance hosting arrangements	
Anaemia management audit findings	Analysis confirms testing occurs but often outside 90-day window due to long waits - Further work planned with Orthopaedics to review pathway timing and impact on outcomes - Consideration of links to LOS and cancellations	SCB QSE
Ombudsman case – failure to inform patient of removal from waiting list	Mandatory communication process introduced (written confirmation to patient and GP) - RTT training refreshed - Local processes strengthened for relisting and follow-up	General Surgery QSE

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
NRI (Nationally Reportable Incidents) position improving	- 8 open NRIs, trajectory improving, with expectation to meet targets ahead of HB timeline - Increased support for PSLR completion and training - Continued oversight via QSE governance	SCB QSE
Incident management (Datix)	High reporting rates maintained (220/month) - Low backlog relative to Health Board - Targeted support offered to teams with older incidents	SCB QSE
ePMA rollout in ITU reducing risk in medicines management	Critical care now live - Remaining areas (paediatrics/obstetrics) scheduled - Risk of paper/electronic interface reducing	Medicines management Group

RECENT LEARNING OPPORTUNITY

Source:	Datix	**Reference (if applicable):**	
What happened / what was the problem?			
Blood transfusion in theatre without completed All Wales Transfusion Record; initial inability to trace administration raised significant safety concern.			
What was learned and how was this shared?			
Reinforced need for full documentation and traceability requirements Discussion held with anaesthetist regarding best practice Learning shared through QSE and transfusion governance processes			
What action has been taken or planned? What was the impact of this?			
Traceability confirmed via anaesthetic chart sticker Improved awareness and compliance expected Case used to reinforce critical nature of documentation standard			

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

- Strong reduction in overdue NRIs and improved incident management processes
- High engagement with MCA support team (4.5x increase in staff seeking advice)
- Cross-site collaboration to maintain patient access (e.g. Ophthalmology referrals to ABUHB)
- Implementation of new perioperative pathways addressing emerging medication safety risk

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.		Digital support and pathway redesign are underway as part of the Health Board's Lost to Follow Up programme to reduce harm from patients lost to follow-up. Progress is ongoing but, due to resource and capacity limits, a completion date cannot be confirmed. Operational priorities affect the project's pace; as resources improve, work will accelerate. The timeline remains open-ended to ensure safe and thorough delivery.	

NEW / CLOSED / AMENDED RISKS

Simplified risk	What this means	Priority actions
Ageing estates impacting patient care	Clinical areas may not receive urgent estates work quickly enough, affecting safety/functionality and care quality.	1) Agree and publish a prioritised programme of urgent works for high-risk areas 2) Continue joint estates/IPC/clinical inspections and update risk registers 3) Progress capital bids/rolling refurbishment programme (e.g., theatres) 4) Put contingency

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

CLINICAL BOARD QUALITY UPDATE REPORT

Governance Group:	C&W CB QS&PE meeting	**Date of Meeting:**	28/4/26
Representative at Clinical Board Governance:	CB, O&G, ACH, CYPFHS	**Date of Meeting:**	

ITEMS FOR ALERT		
Issue / Risk	**Actions Taken**	**Support Requested**
Access to Age Appropriate Mental Health Beds for 16-18yr olds (RR 20)	1. Current UHB protocol identifies the age-appropriate bed for 16–18-year-olds requiring acute mental health admission for a comprehensive psychosocial assessment to be provided by AMH'S at Hafan y Coed. 2. Assessment and management by EWMH Team's including Crisis team and IHTT. Out of hours on call medical team. 3. Functioning Crisis Team to offer support to young person, family and staff on Cedar Ward 7 days a week including bank holidays between the hours of 9am – 9:30pm 4. Medical on call rota available out of hours 7 days a week 5. Escalation process for admission and sourcing of appropriate bed in place but it is not functioning effectively	
Insufficient capacity in ICCNS to deliver statutory care packages (RR 20)	Approval and external advertisement of Band 3 and Band 5 posts. Agreement to recruit to Band 4 AP and for them to administer child specific medications within agreed framework.	Approval of the band 4 medication administration policy
transfer of budget for CHC -LD	£39M transferred over and increased our control over spend by £5.3M. Line of sight to 1.5M saving if POC reviewed.	C&W LD team are reviewing the top 40 cases. Need workforce to undertake the reviews and reduced packages
Richmond support services (domiciliary support) arm of Richmond Nursing Agency disbanded.	Currently 2 Adult LD packages of care supported by Richmond. 1 was under the Richmond support services (domiciliary support) arm for non term-time domiciliary support when person is on leave from collage. Care for immediate period will be undertaken via continuing Richmond Nursing Agency and its governance and assurance frameworks	Support of the interim arrangement for next week's care via the Richmond Nursing Agency arm.
National Respiratory Audit Programme (NRAP) Asthma Audit outlier status	University Hospital of Wales has been identified as an outlier within the National Respiratory Audit Programme (NRAP), in line with the NRAP outlier policy This service has been identified as non-participating hospital/service in the children and young people's asthma audit, for the 1 April 2024 and 31 March 2025 cohort period.	Support has been arranged to maintain compliance going forward

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Support Requested**

Awaiting outcome of current BR+ assessment. Anticipated that the service is likely to be non-compliant with requirements	Assessment is ongoing. Consideration of risk to be undertaken when received.	
Ongoing HV JD review	Move via UNITE to move HV's in C&V to a collective Grievance stage	
Restarting childrens rights forum	Dates being arranged and stakeholders identified	Comms support
Plan for ND delivery plan has gone to UHB Finance Group for ratification	Awaiting outcome from UHB Finance group	agreement

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Support Requested**
Awaiting publication of recent HIW unannounced inspection of B2 Gynaecology	Report received with no significant areas of concern. Incidental findings have been responded to. Able to demonstrate compliance against all recommendations.	Comms support
Recording and Monitoring of Directorate & Clinical Board Risks	All risks have been transitioned to the AMAT system in line with UHB. Regular monthly monitoring and review undertaken across Directorates with monthly reviews being undertaken of all >20 risk rating by the Clinical Board. 3monthly reviews are also being scheduled by Clinical Board to review all risks on an ongoing basis.	AMaT support

RECENT LEARNING OPPORTUNITY			
Source:	NRI Investigation – CR	**Reference (if applicable):**	**ID87558**

What happened / what was the problem?

CR was 12 years of age at the time this incident focuses on. He has a private diagnosis of autism spectrum disorder (ASD) and recent diagnosis of obsessive-compulsive disorder (OCD), who lives with his mum
CR had not attended school for over 8 months at the point of admission due to anxiety. It is documented that he began to show signs of "germophobia" around early March 2025 which mum states coincided with onset of puberty. CR first become known to the Emotional Wellbeing and Mental
Health Service (EWMHS), formerly CAMHS, at Cardiff and Vale University Health Board in 2020. It is documented that he presented with anger management issues. His family were signposted to Families First. CR was referred to EWMH service again in 2024 with high levels of anxiety and school refusal. He would not engage in an assessment and was discharged with recommendations made for support from Children's Services. There was some involvement from Children's Services, but it is documented that CR was closed to them in January 2025.

A GP referral was made to the Single Point of Access (SPOA) for the EWMHS on 4th April
2025 with reported concerns of low mood, symptoms with features being consistent with OCD, and agoraphobia. This referral did not identify an immediate risk so was triaged with a plan for further discussion with the assessment team. This information was shared with the
SPOA from the NHS 111 press2 support service. CR's mother had called them out of
hours reporting that CR was presenting with aggressive behaviour. Safety advice had been given to

mum, advising her to take CR to the Emergency Department or call the police/ Emergency Duty Team in Children's Services if needed.

On 10th April 2025, CR's grandfather called the SPOA requesting an urgent CRISIS assessment for him. Grandfather disclosed the level of physical aggression CR was displaying towards him mum had markedly increased. Police had been called to the house several times. CR was asking his mum to clean the house for 7-8 hours a day, frequently wiping himself with Dettol, and showering frequently for extended periods of time and would get angry if mum did not comply. Two nurses from the Crisis team went out to the family home the following day and this assessment led to a psychiatry review at home, followed by a Mental Health Act (MHA) assessment. CR was detained under Section 2 MHA and admitted to Owl Ward at the Children's Hospital for Wales (CHFW) during the night and he remained an inpatient on this ward until 8th May 2025.

What was learned and how was this shared?

Recommendations

1. Further consideration as to where CYP under 16 yrs of age who are presenting with high levels of dysregulation and aggression are admitted. Risk should be assessed preadmission and on an individual basis and escalated for senior discussion. This was a fundamental issue which widely impacted on safe and effective care to CR and other CYP on the ward.
2. Raised awareness for all staff re: CODA. A presentation prepared by one of the doctors involved in CR's care has been included in the appendices and will be shared for learning.
3. Nurse in change of ward takes responsibility for ensuring all agency staff read *and* individual care plan document at the start of each shift.
4. Request made to head of security to retain security staff body cam footage for more than the agreed 30 days if a child is subject to multiple physical restraints supported by security staff. This may need to be agreed by UHB Information Governance and parental consent discussed.
5. Earlier Tier 4 referral should be implemented. Consider regular use and CHFW joining EWMH team at Ty Liddiard lunchtime huddle for inpatients under EWMH pending Tier 4 referral / need to escalate.
6. Board to request formal meetings with NCCU /JCC regarding Tier 4 provision: gatekeeping process, delay in assessment and expectation of Tier 3 CAMHS / CHFW.
7. Earlier and intensive support on wards from Goleudy /Enfys. Depending on Goleudy capacity this may mean reduced service provision to support other CYP so would need Directorate Management authorisation.
8. Process to ensure earlier assessment of RMN staffing including number of staff to maintain safety and need for agency package to be commissioned. CHFW and CYPFHS do not have access to a pool of RMN's so need assurance from Executive Board that this would be authorised promptly. This would support reliance on security staff being called to support. Crisis do not have capacity to support ward staffing.
9. Training: ward staff and CRISIS should undertake SIMA training. Currently only Adult Mental Health staff and UHB security complete this. Ward staff undertake V&A training, but this does not include floor /bed restraint. It does not meet the needs of patients as dysregulated as CR. The ward is reliant on external staff being commissioned via an agency to provide. Consideration to ED staff also undertaking this.
10. SIMA training for an agreed core staff in CHFW. To discuss with SIMA training leads if programme can be adapted to make it a more child focussed and children's rights based. One Health Boards using PMDA – to compare.
11. Develop a Framework for Reducing Restrictive Practice CYP which includes an agreed clinical pathway, considers environment, staffing, training, incident documentation, data collection and analysis, post incident review, advocacy and children's rights. This needs to be completed jointly with Adult Mental Health Clinical Board and cover adults and children/ young people. Consider other key stakeholders.
12. Training: a basic understanding of neurodiversity and how this may impact a child's presentation /needs. Security staff to be included.
13. Children's Right Awareness – basic training package (can be online) to help raise awareness of vulnerabilities of CYP and their rights. Delivered across staff groups.
14. EWMH service review – self assessment across all teams and management deep dive. To include review of current pathways and consider appropriate timescales for handover between CRISIS and IHTT / CITT teams.
15. EWMH implementation of cross team (CRISIS / IHTT / CITT) peer review meetings in EWMH. This currently happens but is team specific.

16. EWMH and CHFW teams to undertake Mental Health Act Training which includes guidance on the application of emergency MHA application, such as Section 5 (2).

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

The report findings and improvement plan will be shared via the groups below.

- UHB Directorates, Clinical Board QSPE Meetings
- UHB Safeguarding Steering Group
- Referral to Single Unified Safeguarding Review SUSGR Panel (will support learning with both Children's Services and police)

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

C&W creating a sustainability group to consider initiatives which improve sustainability, reduce carbon footprints, save time and money whilst maintaining / improving quality.

Winners & Runner's Up from CAV Nursing & Midwifery Conference:
Julia Barnett – Winner Patient Centred Care Award
Kieran Hughes-Jones – Runner Up in Shaping Future of Care Award
Emotional Wellbeing & Mental Health Team – Runner Up of Nursing & Midwifery Team of the Year
Rhian Clark – Winner Innovation in Nursing & Midwifery
Community Practice Educators for Health Visiting – Runner Up Mentorship & Education
Simon Cave – Runner Up Outstanding Contribution by a Healthcare/Midwifery Support Worker

Youth Worker being employed to support CYB/UNCRC/Noah Ark ambassadors

Roster coordinators in place and use of bank reducing

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)
	1 overdue maternity HIW action			
	X5 Overdue NRI's:			
IN90636 (RA)	PSLR being reviewed	Oct 2025	Further work required following queries raised via PST, almost ready to be sent for final review and sign off. Anticipated closure end of May/beginning of June 2026	
IN92726 (NG)	With Executive Team for sign off and closure	Nov 2025	Delay in progression of investigation. Required reallocation of IO	
IN29271 (AJH)	PSLR initiated following grading of Perinatal Mortality Review	Jan 2026	Originally reported as MBBRACE. Care concerns noted following PMR, PSLR initiated. Anticipated closure June 2026	
IN102543 (PT)	Final Draft to be shared with Patient Safety Team by 26.05.2026	April 2026	PSLR progressing. IO had recent period of sickness. Anticipated closure June 2026	
IN101360 (RR)	PSLR being reviewed	May 2026	Further review required following additional concerns raised at patient	

			debrief session that require consideration as part of the review.	

NEW / CLOSED / AMENDED RISKS

Nil new risks
2 risks were downgraded in May

CLINICAL BOARD QUALITY UPDATE REPORT			
Governance Group:	Quality Committee	**Date of Meeting:**	02.06.2026
Representative at Clinical Board Governance:	PCIC Clinical Board Quality, Safety & Experience Group	**Date of Meeting:**	24.03.2026

ITEMS FOR ALERT		
Issue / Risk	Actions Taken	Group Responsible
Annual MCA Audit Feedback - MCA non-compliance Health Board wide (legal risk)	DDON with support of Consultant Nurse for Older Vulnerable Adults, is instigating a PCIC audit relating to MCA documentation to aid a deep-dive review to understand the issues affecting PCIC	PCIC Clinical Board Quality, Safety & Experience Group
Safeguarding escalation incident management through PHW and CAV - Child Sexual Exploitation (CSE) within the test and post service had not been escalated to the Health Board for management	Incident Management approach with PHW, Department of Sexual Health and Safeguarding	CAV Department of Sexual Health reporting to PCIC Clinical Board Quality, Safety & Experience Group
Heads of Function at HMP Cardiff, are reviewing PPO (Prisons and Probation Ombudsman) recommendations as part of the HMP assurance process. Highlighted that there are over 40 outstanding PPO recommendations for which there is currently no supporting evidence. Many of these are historic and pre-date current postholders.	Ongoing work with HMP team to demonstrate meaningful learning from deaths in custody, a review of the PPO recommendations will be required, with clear evidence of actions and assurance *multiagency approach.	Multiagency (HMP & CAV) via PCIC Clinical Board Quality, Safety & Experience Group

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group Responsible**
PCIC do not currently have an Infection Prevention Control Clinical Nurse Specialist due to vacancy	Head of Infection Prevention Control is progressing recruitment	PCIC Clinical Board Quality, Safety & Experience Group
Issues with timely communication from HIW about inspection visits and outcomes, including lack of notification and immediate action reports.	Deputy Head of Operations for Primary Care Primary Care arranging a meeting with HIW representatives and involve the corporate governance team to address consistent messaging and improve the circulation of inspection notices and	Primary Care Quality and Safety Group Meeting

	reports.	
Minutes reference the absence of Quality Report – this relates to a collated report that has been collated using data from dashboards. The individual quality indicators were presented separately i.e. ipc, safeguarding which includes pressure damage	Agenda review with Chair accepting dashboard data by key KPI's	PCIC Clinical Board Quality, Safety & Experience Group
NMP (Non-Medical Prescribing) Governance Framework	Prescribers are actively updating their Scope of Practice to meet compliance. Anyone non- compliant will not be able to prescribe	PCIC Clinical Board Quality, Safety & Experience Group

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
HIW Inspections in Primary Care with our commissioned partners	Primary Care team work with practices on immediate assurance actions, are followed up with the practice, support offered where necessary and assurance of completion is provided.	Primary Care Quality & Safety
Standard Operating Procedures (SOP) for permitted Medicines/Fluids administration requiring alignment/review	Joint review of SOPs by District Nursing, Community Nursing teams in Safe@Home with the Medicines Management team for Governance and assurance.	PCIC Clinical Board Quality, Safety & Experience Group
Medicines Governance and Safety in PCIC	Introduction of PCIC Medicines Governance and Safety Group (First Meeting 8.4.2026)	Medicines Governance and Safety Group
Risk Register Transfer to AMaT	Transfer to AMaT is ongoing with trajectory to meet deadline of 31st March 2026	PCIC Clinical Board Quality, Safety & Experience Group

RECENT LEARNING OPPORTUNITY			
Source:	Patient Story from Palliative Care Team	**Reference (if applicable):**	
What happened / what was the problem?			
The story was about collaborative working within the hospital Palliative Care Team (PCT) and partner agencies in caring for a 56-year-old woman with learning disabilities and autism, who was initially admitted			

to hospital with constipation and reduced appetite, later diagnosed with metastatic disease.

What was learned and how was this shared?

Key lessons learnt from this case highlight the importance of collaborative, patient-centred care, especially for individuals with complex needs and communication barriers. The involvement of the wider MDT, community colleagues, and her familiar carers ensured continuity and comfort in her final days. Flexibility in symptom management and adapting routines to the patient's preferences were essential, as was maintaining open communication among all stakeholders. The case demonstrates that effective teamwork and understanding the patient's cues can lead to dignified, peaceful end-of-life care, even in the face of significant challenges.

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

Sharing at QSE meetings for wider learning

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Meningitis B outbreak in Kent – Cav taking a proactive approach including catch-up immunisation clinics for children up to two years, with strong uptake for teenage boosters

Hepatitis A outbreak, 29 year two children, four adults, and eight individuals in out-of-school provision in Barry have been vaccinated, with a further 20 14–15-year-olds scheduled for vaccination.

Weekly pressure damage scrutiny panels in place

Proactive monitoring of safeguarding referrals

Review of Child Sexual Exploitation (CSE) - related cases underway with defined deadline

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)
ID93297	Targeted Patient Safety Team Support to close in month	5/12/2025	Capability – New IO with inconsistent support Unavailability of dedicated support	

NEW / CLOSED / AMENDED RISKS

The CB Senior team undertake a Risk Register Deep dive and review outside of QSE but highlight the risk register position through PCC QSE. There is work to do on derisking some risks on the risk register.

CLINICAL BOARD QUALITY UPDATE REPORT

Governance Group:	CD&T QSE Sub-Committee	Date of Meeting:	23rd April 2026
Representative at Clinical Board Governance:	Director of Nursing/Multidisciplinary Teams	Date of Meeting:	

ITEMS FOR ALERT

Issue / Risk	Actions Taken	Group Responsible
The numbers of concerns being received across the Clinical Board to be resolved through early resolution timeframes are increasing.	Themes are being monitored closely at Clinical Board and directorate level to identify if there are specific themes or specific themes related to specific directorates.	CD&T QSE Sub-Committee
Open fire risk actions have been discussed in the Clinical Board Health and Safety Group. Progress has been made to reduce the number of open actions, but large numbers remain open.	The dashboard has been shared with managers with an action to close out outstanding actions or transfer actions that are outside of the Clinical Board's control.	CD&T Health and Safety Group
There is a drive across the Clinical Board to improve VBA and fire training compliance.	Weekly reports are being shared across the Clinical Board filtered by department showing all staff' current compliance.	CD&T directorate performance reviews.

ITEMS TO ADVISE

Issue / Risk	Actions Taken	Group Responsible
The implementation of the new blood gas devices is being undertaken in 2 phases. Paediatric devices are being evaluated separately and will be circulated shortly. This implementation will eliminate the majority of risks relating to blood gases. End to end connectivity has been stable.	Implementation has been undertaken by the Point of Care Testing team flexibly over weekends and late into evenings to allow for training to be delivered to clinicians.	CD&T QSE-Sub Committee
The NHS Wales App went live in January as part of a national process led by Digital Health and Care Wales. Physiotherapy have noted that there have been issues relating to their patients being given details to attend the wrong sites for their appointments.	The Health Board is setting up a group to look at the data quality issues and develop a process for checking clinical information in PMS and Patient Information Systems.	UHB Data Quality Group - TBC
The Patient Safety Team have undertaken an unannounced audit on medicines storage with support from Pharmacy colleagues. This was a theme highlighted by HIW when they visited clinical areas where they noted that drugs were left unattended and unlocked. Formal feedback is awaited	Formal report to be produced.	

ITEMS FOR ASSURANCE

Issue / Risk	Actions Taken	Group Responsible
Haematology was assessed by the regulatory body UKAS on the QMS and technical side of Haemostastis & coagulation. The assessor was complimentary of the risk assessment management, document control and change controls. Complimentary feedback was also received in relation to the staff attitude and leadership within the team. Minor non-conformances that were raised are easily rectifiable.	An action plan will be developed to monitor progress and closure of the non-conformances.	CD&T QSE Sub-Committee
Cellular Pathology also received a very positive outcome for their UKAS accreditation inspection with very few findings. Excellent feedback was received from the assessor on the quality of the service and the team.	An action plan will be developed to monitor progress and closure of the non-conformances raised.	CD&T QSE Sub-Committee
Mandatory training compliance across the Clinical Board is above 85%. Fire training compliance is currently at 80%.	As noted in the Red Alert, weekly reports are being circulated to departments showing staff's current compliance. Compliance against the Health and Safety modules are reviewed in the Clinical Board Health and Safety Group. Individual directorate performance against targets is monitored in the Directorate Performance Reviews.	CD&T Health and Safety Group CD&T directorate performance reviews.

RECENT LEARNING OPPORTUNITY

What happened / what was the problem?

A personal injury claim was submitted to the UHB related to the Live Well Therapy Team. During an exercise class held in a leisure centre in Cardiff, a TRX strap came away from a wall causing the patient to fall. The investigation highlighted that the strap had been attached to the wrong fixing on a wall.

The class was jointly run by GLL employees and a CAV technician who provides support. The GLL employee was unavailable on the day of the incident and the NHS staff ran the class independently. The straps are not NHS equipment and had been attached to the wall prior to the class.

What was learned and how was this shared?

It was deemed that Physiotherapy had exposure as the service could not evidence a safety check of equipment, even though responsibility does not lie with the services. Other departments providing care in the community in these types of premises can learn from this incident in that robust agreements clearly outlining accountability and responsibilities of all parties must be drawn up. This is particularly important given the use of third-party premises to provide care closer to patients' homes is the direction of travel in NHS Wales.

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

Settlement was agreed with a 50/50 apportionment for both parties. Following this outcome joint GLL and NHS Groups have been paused whilst a new agreement is drawn up, with clear lines of responsibility for equipment.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

The Therapies CRI team received a Diverse Cymru Silver Award for their cultural competence work. At the next meeting in May, the Therapies Equality Lead will be presenting an overview of the Equality and Inclusion work that has been undertaken across Therapies and their plans for progressing this work further in 2026/27.

The Bleeding Disorders Pharmacist for the Bleeding Disorder Network Wales, presented a patient story where a patient's life was transformed through Hemgenix Gene Therapy treatment, a very new novel therapy for Haemophilia B. This is a one-time treatment that should significantly reduce or even eliminate the need for any Factor IX infusions. The first patient in Wales was administered Hemgenix in January. The SMPU Unit upgraded its infrastructure to aseptically prepare and manufacture the product as specific standards had to be met. The support and efforts of the SMPU staff have been acknowledged, as this therapy could not have progressed without their efforts. Since receiving the therapy, the patient's factor levels have been closely monitored and they have not needed to continue receiving injections. Going forward, the impact on this patient's life should reduce the risk of bleeding. Reduce the risk of joint disease and the need for associated treatments and reduce the risk of surgical interventions related to admissions due to bleeding. Their quality of life will be much improved allowing them more freedom and the ability to take holidays without worrying about storing and taking treatment.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)
NRI 105327	A full investigation and root cause analysis is being undertaken by the provider to determine the cause of the temperature excursion. This includes a revie of equipment performance, alarm functionality and monitoring data.		The investigation is reaching a close and will include any corrective or preventative actions identified.	Green

NEW / CLOSED / AMENDED RISKS

No new risks have been raised.

The Clinical Board is undertaking moderation work relating to the scoring of risks. Meetings have been arranged with directorates to review their risk registers and update the narrative and scoring of risks, particularly for long standing risks where the likelihood scoring can possibly be reduced.

There is an agenda item on the QSE Sub-Committee specifically related to risk management. Under this agenda item going forward, directorates will be asked to present their top risks.

CLINICAL BOARD QUALITY UPDATE REPORT

Governance Group:	Specialist Services QSE Committee	**Date of Meeting:**	7/5/26
Representative at Clinical Board Governance:		**Date of Meeting:**	

ITEMS FOR ALERT

Issue / Risk	Actions Taken	Group Responsible
CB specific items as per directorate escalations noted in QSE Committee Minutes for May 7th 2026		
Annual MCA audit feedback shared and demonstrated widespread gaps in documentation of capacity assessments despite indications assessments occurring. □ **Key risks identified:** • Documentation absent in **~two-thirds of cases**. • **8% of cases** showed clear indication MCA should have been applied but wasn't considered. • **Restraint processes often non-compliant**, with lack of evidence of capacity assessment or best interest decisions. • Use of non-specific language ("seen in best interests") undermining legal compliance. □**Risk implication:** Potential **legal, safeguarding, and patient rights breaches** across the UHB.	All directorates asked to share at local Q&S sessions and encourage engagement and training and to advise re. pro formas and documentation tools CB champions nominated and requested invites to meetings	CB QSE Committee Local Q&S leads and groups
Fire safety training compliance drive and capacity / delivery constraints	Cath Twamley to reach out to Ryan Paxford for clarification around some training queries and whether Teams sessions count as F2F	CB QSE Committee
Infrastructure and Service resilience issues as per CB QSE minutes and Risk register		
Gentamicin Safety Notice	Already widely shared but headlines discussed and for sharing locally	

ITEMS TO ADVISE

Issue / Risk	Actions Taken	Group Responsible
Helipad Closure (Imminent Operational Risk) • Planned closure for fire system upgrades • Mitigation: transfer via alternative landing site and ambulance transfer • Potential impact on **time-critical patient transfers**	Awareness raised. Kevin Nicholls (DM MT) to attend relevant operational/ organisational meetings and share comms as indicated	Major Trauma DMT
Tier 1 & Tier 2 audits	Reconciliation of audits in progress to support QMS	
Cardiac Device paper to be presented at Quality Board June 30th	Drafted	CB SLT and DMT

ITEMS FOR ASSURANCE

Issue / Risk	Actions Taken	Group Responsible

Improvements seen in C.diff., MSSA and Pseudomonas trajectories demonstrating effective interventions Improved RCA compliance to inform learning.	CB live IP&C action plan as per Specialist IP&C Group	
Successful **EPMA** rollout in Critical Care strengthening medication safety	Completed 6th May 26	ePMA and CC team

RECENT LEARNING OPPORTUNITY

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

What happened / what was the problem?

Risk identification and discussion improving through structured governance (AM@T) enhancing visibility, escalation and scrutiny.

What was learned and how was this shared?

Notable at QSE Committee and Performance R/Vs

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

Has highlighted need for objective discussion and moderation.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Introduction of the “The Druggle” (a drug huddle) on Ward C5 and spread and scale initiative from Critical care. Druggle offers short, bite-sized, informal sessions focusing on:

- Medication and patient safety
- Staff education
- Sharing good practice
- Highlighting areas for improvement

Staff engagement was excellent, with very positive feedback on the format and content.

Druggle will take place every Friday at 13:30 **on Ward C5**
All staff are welcomed to attend this great opportunity to learn, share and strengthen safe practice

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)
73028 112097	Completion of ‘Cardiac Device Action Plan’		Actions implemented in practice but operational challenges and priorities to mitigate actual risk have taken priority	
101295	Sign off of ‘Transplant Service Escalation Plan for Service Gaps’			

NEW / CLOSED / AMENDED RISKS

Positive movement in **Neuro** with review and reduction of previously high-scoring risks due to local mitigation, actions and improved stability in the Epilepsy Service.

RTT (Referral to Treatment) Pressure – Partial Improvement

- A previously escalated RTT target risk (e.g. Taf pathway) has been removed/reduced following:
  - Sustained operational effort and intervention

- Indicates improving performance trajectory, though:

Haematology:
Some risks have been successfully reduced/closed, including:
- Recruitment to senior nursing posts to include TCT, haemostasis services
- Progress on ALL CNS recruitment (All-Wales role)

CLINICAL BOARD QUALITY UPDATE REPORT

Governance Group:	Mental Health Clinical Board – Quality, Safety & Experience (QSE)	**Date of Meeting:**	02/04/2026
Representative at Clinical Board Governance:	Clare Quinn (Chair), Director of Psychology and Psychological Therapies	**Date of Meeting:**	02/04/2026

ITEMS FOR ALERT

Issue / Risk	Actions Taken	Group Responsible
Significant concerns identified in MCA audit including poor documentation, unlawful restraint, and lack of DOLS application	Action plan in development including new documentation templates, enhanced Level 3 & 4 training, staff survey, and additional guidance	MCA Lead / Safeguarding / MHCB
Staffing shortages impacting inpatient services and statutory functions	Ongoing recruitment activity, conversion of bank staff to substantive posts, and introduction of senior inpatient nursing role	MHCB Leadership / Workforce
EPMA system risks including demographic mismatches, DAL completion issues, and lack of MHA alerts	Additional staff training, system improvements, interim manual controls, and development of alert systems	Pharmacy / Digital / MHA Office
HIW inspection findings (IPC, environment and cleanliness issues within MHSOP wards)	Immediate actions completed, with ongoing improvement plan and monitoring via governance structures	MHSOP

ITEMS TO ADVISE

Issue / Risk	Actions Taken	Group Responsible
Risk register migration to AMAT system resulting in incomplete visibility at meeting	Updated AMAT risk register to be circulated and used for future review *(please note, following QSE meeting, all risks have been migrated)*	Corporate Governance / MHCB
System pressures including bed capacity and patient flow challenges	Ongoing monitoring and escalation through governance arrangements – Out of Area and Flow workstreams commenced.	Directorate Teams
Substance misuse prescribing service transition (Dafodol)	Interim prescribing arrangements and additional	Pharmacy / Substance Misuse Services

	pharmacy support in place pending Home Office licence	
Low referral rates to Recovery & Wellbeing College discharge course	Engagement planned with CMHTs to improve awareness and referral pathways	Lived Experience Team / CMHTs

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Implementation of Martha's Law within MHSOP services	Escalation mechanisms implemented and staff awareness reinforced	MHSOP Services
Infection Prevention & Control performance (DMT scores ~93–94%)	Continued monitoring and effective outbreak management processes	IPC Team
HIW inspection readiness arrangements	Monthly training compliance reporting, strengthened audit processes, and improved documentation visibility	Quality Team / QSE
Learning from incidents embedded in practice	Improvements to handover, observation and leave processes implemented and monitored	Patient Safety
Rapid Review Tool	QSPE Senior Nure presented the new rapid review form which replaced the fact finding as an initial review and escalation for serious incidents.	Patient Safety
Patient Safety Review Bulletin	Key patient safety themes emerging from reviews, and incident numbers cascaded within the patient safety review bulletin. Next shared learning event (safety and risk formulation) May 8 2026	Patient Safety

RECENT LEARNING OPPORTUNITY			
Source:	Learning from Events	**Reference (if applicable):**	Historic incident review (Section 2 patient absconding)
What happened / what was the problem?			
A detained patient absconded from care and sustained harm. The review identified failures in observation levels, handover processes, and management of Section 17 leave.			
What was learned and how was this shared?			

Learning identified the need for improved clarity in observation levels, strengthened documentation, better communication during transfers, and improved oversight of leave. Shared through governance forums and safety meetings.

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

- Strengthened handover documentation requirements
- Improved observation practices and leave management processes
- Enhanced ward sign-out and patient tracking systems
- Ongoing monitoring through governance arrangements

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

- Positive outcomes from Recovery & Wellbeing College, supporting patient empowerment and engagement
- Effective contingency arrangements during EPMA downtime (safe reversion to paper systems)
- High Infection Prevention & Control compliance across wards despite operational pressures
- Expansion of multidisciplinary Tendable audits, improving ownership of quality

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)
N/A (General)	Timeliness of NRI review completion	Ongoing	Delays in review completion; improvement plan in development	

NEW / CLOSED / AMENDED RISKS

- Risk register transitioned to AMAT system
- Existing risks reviewed and rationalised during migration
- No new risks escalated at this meeting

<table>
<tr><td>Report Title:</td><td colspan="2">Claims Annual Report 25/26</td><td colspan="2">Agenda Item No:</td><td>4.3.1</td></tr>
<tr><td rowspan="2">Meeting:</td><td rowspan="2">Quality Committee</td><td>Public</td><td>√</td><td rowspan="2">Meeting Date:</td><td rowspan="2">2 June 2026</td></tr>
<tr><td>Private</td><td></td></tr>
<tr><td>Lead Executive Title:</td><td colspan="5">Executive Nurse Director</td></tr>
<tr><td>Report Author/s Title:</td><td colspan="5">Assistant Director of Patient Experience</td></tr>
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Report Focus Summary – **AAA Framework:**

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

The 2025/26 claims profile demonstrates an increase in clinical negligence claims (108 claims) alongside ongoing personal injury risks.
There is clear evidence of system-wide risks rather than isolated events, particularly relating to:

- Delays in diagnosis, treatment, and escalation
- Failures in communication and documentation
- Environmental and estates-related hazards

Learning Advisory Panel findings highlight a critical gap between actions identified and demonstrable assurance of impact, indicating a governance and system reliability risk.
This presents:

- Patient safety risk (harm from delays and failures in escalation)
- Financial risk (increasing high-value claims, especially maternity)
- Reputational risk (failure to evidence learning and improvement)

Immediate focus is required on system controls, pathway reliability, and assurance of learning effectiveness.

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 report provides an update on:

- Increasing trend in claims activity consistent with All-Wales position
- Strong alignment between claims, complaints, incidents and Learning from Events
- Continued improvement in timeliness and quality of Welsh Risk Pool submissions

Emerging developments include:

- Implementation of Listening to People (April 2026)
- Increase in redress threshold to £50,000, shifting more cases into local resolution
- Increased requirement for early decision-making and robust documentation

Operationally, priorities include:

- Strengthening early resolution pathways
- Improving triangulated intelligence through integrated dashboards
- Enhancing Clinical Board engagement in learning from claims

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

The Committee can take assurance that:

- Claims are managed in line with Welsh Risk Pool procedures and national guidance
- There is strong triangulation of claims with complaints and incident data
- Timeliness of Learning from Events submissions is improving
- Active engagement with Welsh Risk Pool is strengthening learning quality

However, assurance is partial in relation to:

- Demonstrating sustained impact of learning
- Consistent embedding of system-wide improvements

- Reliability of pathway controls in high-risk areas

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

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

The Committee is asked to:

1. **Note the increase in claims activity and associated system risks**
2. **Recognise the escalation of key risks relating to:**
   - **System reliability and pathway delays**
   - **Gap between learning and assurance**
   - **Estates and environmental risks**
3. **Seek assurance on:**
   - **Strengthening of escalation and diagnostic pathways**
   - **Evidence of measurable and sustained learning**
   - **Reduction in reliance on individual compliance vs system controls**
4. **Support escalation of key risks to the organisational risk register where required**

Governance Route ***(please list all other Committee/Groups this report has been to)***	
***Where** it's been:*	*Shared with WRP as part of assessment*
***When** it went:*	
***What** decision was made:*	

Main Report
Background & Current Situation

*The 2025/26 claims position demonstrates a **continued increase in clinical negligence claims and sustained levels of personal injury claims**, reflecting both local and national trends.*

*Analysis confirms that claims arise from **recurring system-wide themes**, including:*

- *Delays in diagnosis and access to treatment*
- *Failures in recognising and responding to patient deterioration*
- *Communication and handover breakdowns*
- *Documentation gaps impacting continuity of care*
- *Environmental and workplace safety risks*

These themes are consistent across:

- *Claims*
- *Complaints*
- *Patient safety incidents*
- *Learning from Events reports*

Key risks are particularly concentrated in:

- *Acute and maternity services*
- *Time-critical clinical pathways*
- *Estates and operational environments*

*Whilst there is clear evidence of organisational learning and improved engagement with Welsh Risk Pool processes, **Learning Advisory Panel feedback highlights a persistent gap between action and assurance**, with limited evidence of sustained impact.*
*Looking forward, the implementation of **Listening to People** and increased redress threshold presents both an opportunity and risk, requiring:*

- *Stronger early resolution processes*

- *Improved system reliability*
- *Enhanced governance and assurance*

Appendices:

- Appendix 1: Annual Claims Report 2025/26

Strategic Alignment – Shaping Our Future Wellbeing:

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

Impact Assessment

Risk: Yes

Significant risks identified relating to patient safety, governance, financial exposure, and system reliability (detailed within report).

Safety: Yes

Direct impact on patient safety including harm from delays in diagnosis, treatment, and escalation failures.

Financial: Yes

Increasing claims volume and high-value cases (particularly maternity) present ongoing financial pressures and long-term liabilities.

Workforce: Yes

☐ Impact on staff involved in claims
☐ Risk associated with manual handling, workplace safety, and operational pressures

Legal: Yes

Compliance required with:

- *Welsh Risk Pool procedures*
- *Civil Procedure Rules*
- *Listening to People framework*

Reputational: Yes

Failure to demonstrate learning and improvement may impact public confidence and regulatory scrutiny.

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

n/a

Equality & Health: Please select

n/a

Decarbonisation: No

n/a

Welsh Language: No

n/a

Report Title:	Patient Experience Annual Report 2025–2026		Agenda Item No:		4.3.2
Meeting:	Quality Committee	Public	√	Meeting Date:	2 June 2026
		Private			
Lead Executive Title:	Executive Director of Nursing				
Report Author/s Title:	Assistant Director of Patient Experience and Head of Patient Experience				

Report Focus Summary – AAA Framework:

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

A limited number of emerging risks have been identified concerning the capacity and sustainability of essential patient experience functions, particularly in areas dependent on single-post roles (e.g., the Digital Stories service) and where demand for services such as feedback analysis, volunteering, and unpaid carer support continues to increase.

Rising population needs and persistent health inequalities may exert further pressure on these services, highlighting the necessity for ongoing prioritisation, resource optimisation, and scalable delivery models.

The combination of increasing demand across patient experience services and capacity constraints in critical delivery areas poses a challenge to the long-term sustainability and scalability of certain functions.

Absent sustained organisational attention and investment, there remains a potential risk to upholding timely feedback responses, equitable access, and the comprehensive implementation of national frameworks, including the Accessible Information Standards and the People's Experience Framework.

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 report outlines ongoing areas of development and oversight, including:

- Further embedding of the NHS Wales People's Experience Framework across all services
- Continued development of accessible communication standards, including implementation of the Accessible Information and Communication Standards Framework
- Expansion of patient feedback systems and digital capability, including Civica platform optimisation and real-time insight
- Strengthening learning from feedback, including "You Said, We Did" approaches and integration into quality improvement processes
- Workforce and infrastructure development to support:
  - Growth in digital storytelling and lived experience work
  - Expansion of volunteering and patient voice roles
  - Ongoing unpaid carer identification and support pathways

These areas will require continued monitoring through governance structures to ensure delivery against 2026/27 priorities and sustained impact across the organisation.

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

This report provides comprehensive assurance that Cardiff and Vale UHB is effectively listening to, learning from and acting on patient, carer, staff and community experiences, in line with the NHS Wales People's Experience Framework and statutory duties under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Key assurance points include:

- Strong systems for capturing feedback at scale, including up to 1,000 patients surveyed daily and over 192,000 contacts issued in-year
- Evidence of high satisfaction levels, including overall patient experience scores around 84
- Demonstrable impact of "You Said, We Did" improvements, digital storytelling, and service redesign driven by lived experience.
- Robust service delivery across key patient experience functions, including bereavement support, chaplaincy, unpaid carers, voluntary services, accessible standards, enquiries, and information services.
- Clear alignment to quality improvement, population need and reducing inequalities across Cardiff and Vale.

The report evidences a mature, embedded patient experience system contributing to organisational assurance, continuous learning and service improvement.

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

Recommendations*:*

The Committee is asked to:

1. Receive the Patient Experience Annual Report 2025–2026 for assurance on the effectiveness of systems for capturing, responding to, and learning from patient experience.
2. Take assurance from the evidence of high levels of patient satisfaction and the impact of experience-led improvements.
3. Note the priorities for 2026–2027, including:
   - Strengthening accessible information standards
   - Expanding volunteer and unpaid carer support
   - Embedding digital storytelling and lived experience
   - Enhancing feedback systems and survey accessibility
4. Support continued organisational focus on embedding patient experience as a core driver of quality, safety and service 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 Annual Report April 2025-March 2026 (6) (1) provides a comprehensive overview of how the Health Board listens to, learns from, and acts upon patient experience, aligned to the NHS Wales People's Experience Framework and statutory duties.

Population Context

- Growing and ageing population across Cardiff and the Vale

- Significant health inequalities linked to deprivation
- Increasing demand due to long-term conditions and complex needs Key Areas of Delivery
-

The Patient Experience function delivers across:

- Accessible standards and communication
- Bereavement and chaplaincy services
- Unpaid carer support
- Voluntary services
- Patient feedback and surveys
- Digital storytelling
- Information and support centres
- Eye Retrieval Service Key Achievements (2025–2026)
- Patient Feedback:
  - 192,000+ SMS surveys issued
  - ~29,465 survey responses
  - 84% overall satisfaction score
- Voluntary Services:
  - 383 volunteers contributing
  - 11,000+ hours and 35,000+ interactions
- Unpaid Carers Support:
  - 163 interactions delivered during pilot
  - New targeted services (e.g. mental health drop-in sessions)
- Enquiries Service:
  - 2,782 patient enquiries handled
- 504 general enquiries responded to
- Digital Stories:
  - Governance-level use for learning and improvement
- 120+ staff trained
- Chaplaincy & Bereavement:
  - 5,700+ patients/families supported
  - National framework implementation underway
- Eye Donation Service:
  - New service established with 42 consents achieved

Quality & Improvement

- Strong “You Said, We Did” culture
- Feedback embedded into service redesign
- Increased digital engagement and real-time reporting

Priorities 2026–2027

- Expand volunteer workforce and patient voice roles
- Embed Accessible Information Standards
- Develop digital storytelling capacity
- Improve survey accessibility and integration
- Strengthen carer identification and support
- Enhance organisational learning from feedback

Appendices:

- Appendix 1 – Patient Experience Annual Report 2025/26

	X		X

Delivering in the Right Places	X	Acting for the Future	X

Impact Assessment
Risk: Yes
Patient experience feedback highlights areas for improvement; risks are actively managed through governance, escalation and quality improvement processes (referenced in main report).
Safety: Yes
Patient feedback contributes directly to identifying safety concerns and informing improvement actions; processes are embedded within governance systems.
Financial: No
Not applicable – report for assurance; no direct financial decisions required
Workforce: Yes
Significant contribution from staff and volunteers; workforce capacity (e.g. digital storytelling, carers support) identified as future consideration
Legal: Yes
Aligned to statutory duties under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and Duty of Quality/Engagement.
Reputational: Yes
Positive assurance regarding patient experience supports organisational reputation; failure to respond to feedback would present reputational risk.
Socio Economic: Yes - *https://www.gov.wales/socio-economic-duty-guidance*
Report demonstrates consideration of inequalities and deprivation impacting service use and experience.
Equality & Health: Yes
Significant focus on accessible information, inclusive services and reducing inequality in access and experience.
Decarbonisation: No
N/A
Welsh Language: Yes
Surveys and services available in Welsh and multiple languages, supporting “More than Just Words” standards and Accessible Standards

ALERT, ADVISE, ASSURE (AAAs) HIGHLIGHT REPORT	
Committee/Group	**Safeguarding**
Meeting Date	11/03/2026
Lead	Executive Nurse Director
Report by	Deputy Executive Nurse Director

This summary highlights matters arising from the Safeguarding Steering Group held on 11 March 2026 for escalation to Quality Committee under the headings of Alert, Awareness and Assurance.

The next Safeguarding Steering group is on 2 June 2026 and therefore not able to provide any further immediate highlights to Quality Committee.

ALERT

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

Key areas requiring attention include low or variable compliance across safeguarding, MCA, consent and VAWDASV training in a number of Clinical Boards, with particular concern regarding medical and dental staff attendance and data capture from different training sources.

The MCA update also highlighted a recent audit showing limited awareness and understanding of how to apply the Mental Capacity Act in practice.

In addition, the Emergency Department reported a business intelligence system failure which meant retrospective identification of some vulnerable cohorts could not be completed for part of January, demonstrating a current dependency on digital coding systems and limited contingency arrangements.

ADVISE

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

The Group received updates on safeguarding activity across Clinical Boards, including referral volumes, open Section 5 cases and pressure damage reporting.

There was discussion on the 2026/27 training schedule, including the move of some level 2 provision to online delivery, the standardisation of level 3 training, and the scale of the VAWDASV training requirement across the organisation.

The Group also considered the implications of the Baroness Casey audit, including themes of delayed recognition, inconsistent recording, variable multi-agency coordination and the need for a coordinated organisational response.

Nationally, members were advised of developments in digital sexual health reporting and multi-agency retrospective review processes for safeguarding-related cases involving young people.

ASSURE
(Detail here any areas of assurance that the committee has received)
Assurance was provided that safeguarding oversight remains active through regular Clinical Board reporting, review of referrals and open cases, and follow-up through the Safeguarding Steering Group action log. Actions are in place to improve training accuracy and compliance, including correction of staffing data in ESR, clarification of how external training attendance is recorded, and escalation of low attendance in specialist services. The MCA team reported reduced DoLS waiting lists following increased assessment capacity, and further work is planned through a staff survey to understand barriers to training and target support. Reassurance was also provided that the sexual health service pathway is under review and considered safe, with expectation that appropriate safeguarding referrals are made where risk is identified.